S. HRG. 103–1013

HEALTH CARE FOR NONWORKING PEOPLE BETWEEN AGES 55 AND 64

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

JUNE 10, 1994

Printed for the use of the Committee on Finance

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HEALTH CARE FOR NONWORKING PEOPLE BETWEEN AGES 55 AND 64

FRIDAY, JUNE 10, 1994

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Washington, DC.

The meeting was convened, pursuant to notice, at 10:16 a.m. in room SD–215, Dirksen Senate Office Building, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Also present: Senator Rockefeller.

[The press release announcing the hearing follows:]

[Press Release No. H–38, June 9, 1994]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARING ON HEALTH CARE FOR EARLY RETIREES

WASHINGTON, DC—Senator Donald W. Riegle (D–MI), Chairman of the Committee on Finance, Subcommittee on Health for Families and the Uninsured, announced today that the Subcommittee will hold a hearing on health care issues concerning early retirees.

The hearing is scheduled for *10:00 A.M. on Friday, June 10, 1994,* and will be held in room SD–215 of the Dirksen Senate Office Building.

In announcing the hearing, Senator Riegle stated: "We are holding this hearing to examine the health care needs of the pre-Medicare population, those between 55 and 65 who are not in the workforce and not yet eligible for Medicare."

"Failure to deal with the unique needs of this population will leave millions of Americans without access to affordable health care coverage. The majority of this group are on fixed incomes, have more health problems than average, and have difficulty or find it impossible to get affordable insurance." Senator Riegle said.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator RIEGLE. The committee will come to order. Let me welcome all those in attendance this morning. I apologize for the delayed start. We had a vote scheduled late last night to occur right at 10:00 o'clock, so we were in the midst of that vote now, and that necessitated the later start than scheduled.

This is an important hearing this morning, and I want to particularly thank our witnesses for coming today. I think as they have a chance to be heard we will understand why this issue is a key aspect of the subject of health care reform.

The focus of our hearing today deals with the treatment of the pre-Medicare population, workers who are approaching Medicare age but not yet there, those between the ages of 55 and 64, and

particularly those not in the work force. This group, consisting of eight million people, is uniquely vulnerable and should be a priority under a health care reform plan.

Why? Because they have increasing health care needs as they go into that age range, they have problems finding affordable health care, they often have limited financial resources and usually, as well, restricted work options. The majority of this population have lower moderate incomes and represent a growing number of the uninsured people in our country.

I was very pleased to see President Clinton's plan contain a provision that helps make insurance affordable for this pre-Medicare population. These people are often referred to as early retirees, but we should discard that label. That is a false label, and it is misleading, and it tends to distort an understanding of the real problem facing people in this group.

The portion of this population making the choice to retire early is actually a very small percentage. Some two-thirds of non-working people between the ages of 55 and 64 are out of the work force due to layoffs, or just outright job loss. Others are forced out of the work force because they have health problems of one kind or another which actually prevent them from working.

This population includes people like Dean and Doris Darling from St. Helen, Michigan. Dean had to quit his job with a trucking company because of a disabling heart attack. He was age 63. Doris, who also developed a heart condition, was forced to retire at age 57. They were not yet eligible for Medicare and could not purchase outside insurance because of the high cost, and because, also, of their pre-existing health conditions.

So, lacking health insurance coverage, they have now racked up medical bills totaling thousands of dollars. For example, just two angioplasties for Doris alone cost $38,000. They are slowly and painfully trying to pay off this debt on a limited income. They are not alone. There are a lot of people in situations comparable to this.

Many in this population group are falling through the cracks and, as I say, this group is increasing in numbers within our society. They are not yet eligible for Medicare and they have to purchase private insurance on their own, which very often they cannot do.

Fifteen percent of this group, some 2.7 million of the pre-Medicare population, do not have any insurance at all. Others have low or moderate incomes, but too much to qualify for government assistance and must pay a very large portion of their income for what insurance coverage they do have.

I think our goal must be to achieve universal coverage and guaranteed benefits as a package for all Americans. If we do, some of the problems, such as denial of coverage due to pre-existing conditions, will go away.

If reform is employer-based, however, affordable coverage will still be out of range for many of the pre-Medicare population who do not work and, therefore, are no longer in the work force. Access then to health insurance by itself is not enough, it has to be affordable access relative to one's income level.

Now, some have said that we should not worry much about these people or move to help them because we will be bailing out some of the major manufacturers in the country who have retirees that are in this age range, and some cite the auto industry or other manufacturers.

In fact, only 40 percent of the pre-Medicare population have health benefits from former employers, and that percentage is dropping sharply because employers are backing away from providing insurance to their employees, so this is a growing problem for an ever larger number of people.

Only four percent of employers provide any benefits to former employees, so that is the spread now—96 percent do not, four percent do—but even that is a dwindling percentage. Further, as I say, employers have been dropping or reducing early retiree benefits.

Foster Higgins has done a study documenting these reductions, and I ask that their written testimony be part of the hearing record this morning, and we will make it such.

[The prepared study of Foster Higgins appears in the Communications section of the appendix.]

Senator RIEGLE. I also want to say, just with respect to the automotive companies—because, again, this is a very misleading element of this discussion—that auto company retirees account for only 3 percent of the total non-working pre-Medicare population. So, yes, there are 3 percent, but there is 97 percent that is somebody else, and that is, I think, what we have to focus our attention on.

The people who would gain the most from a pre-Medicare program such as the President has laid out or something close to it are people like the Darling family in St. Helen, Michigan that I have referenced this morning.

While companies who have provided benefits, to their credit, to some in this group may benefit as well, this is not a reason to deny this large problem and to turn our backs on an important public policy initiative that we should take in the context of health care reform.

I would say, further, that U.S. companies which pay retiree health benefits also must compete, in many instances, directly against tough foreign competition by foreign companies which do not pay these benefits.

Other competitors, the foreign competitors as well, may have younger employees and fewer retirees and, therefore, not have the financial burden that attaches in this situation.

These companies today are paying a disproportionate load of America's health care bill and these companies, I think, should not be penalized for providing these benefits as they have been doing in the past, and that is one of the things that needs to be reconciled here in this legislation.

So I am very much looking forward to the hearing this morning and what our witnesses have to say. We have a very distinguished panel. I now want to introduce them all, and then I will call on them in this order.

Our first witness will be Mr. Jerry McEntee, who is the International President of the AFSCME union. He is here representing the Pre-Medicare Health Security Coalition.

The Pre-Medicare Coalition represents a large range of organizations, including business, labor, and consumer organizations. He will speak in favor of the proposal in the Clinton plan and discuss the very pressing and real needs of the pre-Medicare population.

He will be followed by Mr. William Custer, who is the Research Director of the Employee's Benefit Research Institute. Mr. Custer will speak about the number of non-working people between the ages of 55 and 64, as well as their health and insurance status, and, where it exists, the employer-based retiree health care coverage.

He will be followed by Mrs. Susan Tanaka, who is Vice President of The Committee for A Responsible Federal Budget. Ms. Tanaka will discuss her concerns about creating a separate provision for the pre-Medicare population, and she will focus on the costs and the impact upon the deficit.

Mr. Perry Amsden is a member of AARP's National Legislative Council, and is from Brewer, Maine. He will be here today to focus on the health needs of this population and he will also be putting a human face on this problem by providing individual stories of people in this circumstance.

I want to say, also, that Senator Mitchell very much wants to try to come by this morning. He is over on the Senate floor because we have a situation that requires his attention. I just left him before coming here from the vote. I know if he is able to break free and get over here he wishes to do so, because he wanted to particularly be part of introducing you and hearing your testimony. So, we welcome you very much.

So we will proceed in that order. President McEntee, it is always a pleasure to see you. I am glad to have you as our lead-off witness today, and we would like to hear from you, now.

STATEMENT OF GERALD E. McENTEE, INTERNATIONAL PRESIDENT, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, WASHINGTON, DC

Mr. MCENTEE. Good morning, Mr. Chairman. I would like to thank you, and the subcommittee, for the opportunity to testify about the impact of health care reform on workers and retirees.

As the leader of the Nation's largest union of public employees and health care workers, with 1.3 million active members and 160,000 retirees, I want you to know that there is no more crucial issue before you than the health security of all Americans.

I am also here today, as you stated, as a member of the Pre-Medicare Health Security Coalition. This is a broad-based coalition of unions, corporations, State and local government organizations, aging groups, and other public interest organizations. A list of those participating in the coalition is attached to my testimony.

In our employer-based health care system, those who are not working are at a real disadvantage. Currently, one-fourth of the over 21 million Americans age 55 to 64 are not working and frequently have either inadequate health care coverage or none at all.

Workers 55 to 64 have become increasingly vulnerable to being laid off, displaced, forced to take early retirement, and the loss of health care benefits. State and local governments faced with budget shortfalls often solve their fiscal problems with forced early re-

tirements and layoffs, as well as wholesale contracting out of public sector services.

Just recently, Mr. Chairman, when New York City, with their new mayor, was faced with a $2.3 billion gap in the budget, Mayor Giuliani and the Municipal unions—the largest of which is AFSCME District Council 37, some 130,000 people—agreed on a severance package designed to avoid some layoffs, if possible.

Six thousand city workers volunteered to leave the city payroll, including 1,200 AFSCME workers aged 55 to 64. They would not have been able to do that, and they would not have done that, unless there had been health care coverage.

These actions in the public sector have been mirrored in the private sector as U.S. companies downsize and pursue a low wage strategy which increasingly utilizes part-time and contingent workers at home and relocates jobs abroad.

Work force reductions through May of this year were running 18 percent ahead of the first 5 months of 1993. Older workers in both the public and private sector, with higher average wages and rapidly escalating health costs, often have great difficulty becoming reemployed.

Workers over age 55 who become unemployed subsequently leave the work force entirely at much higher percentages than younger workers. According to a 1990 CBO analysis, over one-half of displaced workers 60 and older, and over one-fourth of displaced workers between the ages of 55 and 59 left the work force. Of those who do find work, most receive fewer benefits and replace less than 80 percent of their former wages.

We know that hiring discrimination against older persons is fueled, to a great degree, by their high health care costs. Persons in jobs requiring physical labor, jobs that are filled disproportionately by minority workers, are especially vulnerable to job loss as they age. Non-white retirees are only half as likely as whites to have health benefits from former employers, and women are only half as likely as men to have such benefits.

The General Accounting Office estimates that 96 percent of America's employers offer no health benefits to retirees. These former workers are faced with a choice of paying 5-10 times more for health insurance than those with employer paid coverage, often for inferior coverage, or going uninsured, as an estimated 2.7 million people in this age category did in 1992.

While continuation of access to health insurance coverage after early or normal retirement is a common feature of public employer plans, it does not guarantee affordability. Fifteen States make no contribution to the retiree's health coverage at all.

The indemnity plan for non-Medicare eligible retirees from State Government in States represented by members of the subcommittee illustrate the range of assistance. In Michigan, early retirees pay 5.2 percent; in New York, 11 percent; in Minnesota, 25.2 percent; in West Virginia, 74.1 percent; in Missouri, 94 percent; and in New Jersey, 100 percent.

Chairman Moynihan's mark, which we had the opportunity to look at for the first time this morning, makes no provision for the special needs of this group, as you said, Mr. Chairman, numbering in and around eight million Americans.

The President's proposal, which has now been approved, essentially, by the Senate Labor and Human Resource Committee and the House Education and Labor Subcommittee on Labor Management, goes a long way in equalizing the cost of working and non-working persons 55 to 64. In 1991, non-working couples aged 55–64 had a median income of $20,000 and three-quarters of these couples had a family income of less than $25,000.

With the same median income of $20,000, the non—working couple, under the President's plan, would pay 20 percent of the cost of the $800 premium, or 3.8 percent of their income. Under the Ways and Means Subcommittee plan this same non-working couple with $20,000 in income would be required to pay the entire $4,000 premium, or 20 percent of their income, in addition to out-of-pocket costs which can easily reach as high as $2,000-$3,000 per year while the Senate Finance mark ignores them entirely.

The budgetary impact of the provision in the President's bill is to pay the 80 percent "employer share" of the premiums for non-working individuals age 55 to 64 is estimated by the administration to cost $13.4 billion through the year 2000. That cost is fully offset by $17.2 billion in new revenues and savings over the same time period.

Assisting the non-working Americans aged 55 to 64 with health care will not just benefit individuals, but will boost U.S. competitiveness. You mentioned, Mr. Chairman, in your opening remarks, U.S. corporations that still provide retiree health benefits are often hurt competitively. Retiree health costs add about $15 to a cost of a ton of steel at many U.S. steel mills, and an average of $600 to the cost of every car made by America's Big Three auto companies.

Workers, who in the past may have sacrificed wage increases at the bargaining table—and many thousands did—in order to protect health care coverage after retirement have, indeed, struck out twice: foregone wages, and, now, forced early retirement with diminished benefits. Many are likely to face a third strike out—three strikes and you're out—being unable to afford any health care coverage after working as a productive member of the society for decades.

Federal support for early retiree health coverage would produce large savings for State employee health benefit programs and, therefore, relieve the intense pressure on State budgets which are constantly forced into making unacceptable choices about cutting services. States as employers would save an estimated $704 million on premium spending for retirees aged 55 to 64 in the year 2000.

Mr. Chairman, in conclusion, Federal coverage of the employer share for the non-working pre-Medicare population is an important aspect of providing universal coverage which is affordable to all Americans. We appreciate the opportunity to present this testimony, and, at the appropriate time, would be happy to answer any questions.

Senator RIEGLE. Thank you very much for an excellent statement, and a very important and valuable one.

[The prepared statement of Mr. McEntee appears in the appendix.]

Senator RIEGLE. Before we go to Mr. Custer, Senator Rockefeller has joined us. Senator Rockefeller, did you have an opening comment you would like to make?

Senator ROCKEFELLER. Let me hold it for a moment.

Senator RIEGLE. All right.

Mr. Custer?

STATEMENT OF WILLIAM CUSTER, RESEARCH DIRECTOR, EMPLOYEE BENEFIT RESEARCH INSTITUTE, WASHINGTON, DC

Mr. CUSTER. Thank you very much, Mr. Chairman. I am very pleased to appear before you this morning to discuss the health and economic characteristics of those aged 55 to 64.

I am Bill Custer, Director of Research at the Employee Benefit Research Institute, which, as you know, is a non-profit, non-partisan public policy research organization which strives to contribute to the formation of effective and responsible health, welfare, and retirement policies through the provision of objective information.

Consistent with that charter, we do not lobby or advocate positions. We at EBRI have—perhaps inappropriately—labeled this age group the near elderly because no other label fits.

This age group is a very heterogeneous group. Some individuals within this age group find that this period of their lives is when their earnings are peaking, while others are facing difficult financial and health problems. Many people find this the period of their lives when they transition away from employment and employer—based benefits.

As you said, in 1992 there were 21 million Americans between the ages of 55 and 64, comprising 8 percent of the total U.S. population. Of those, eight million individuals, or 38 percent, did not work at all in 1992. Nine percent of the near elderly, or just under two million individuals, did not work because they were either ill or disabled; 14 percent were retired, and 12 percent were taking care of home or family.

Differences in labor force participation manifests itself in differences in family income. The median family income for a working near elderly individual was over $40,000, while the median family income for non-working near elderly was just over $20,000.

The degree to which labor force participation for the near elderly as determined by choice or as forced by deteriorating health is still controversial.

Some researchers discount the possibility that changes in the labor force participation of the near elderly is due to deteriorating health, but, rather, to increased rate of preferences for leisure and the availability of Social Security and other pension income.

Others have evidence that deteriorating health among this population has had a small but significant impact on the lower labor force participation rates.

In any case, it is clear that individuals in this age group have greater needs for health services than younger individuals. EBRI's analysis of the National Medical Expenditure Survey indicates that individuals between the ages of 55 and 64, on average, use 37 percent more health services than those between 45 and 54, and over twice the health care services of individuals between 35 and 44.

Employment is a good indicator of the risk of needing health care services. For the near elderly, our tabulation saw that those who are employed have total health expenditures very near the level of younger individuals, but the non-working individuals age 55 to 64 have health expenditures 65 percent higher than the working near elderly, and those individuals who are non—working due to health or disability have expenditures that are over 2.5 times those of workers.

Though the near elderly have lower labor force participation rates than younger age groups, the majority of those aged 55 to 64 get their health insurance coverage from employment based plans, 64.1 percent.

Almost 13 percent of near elderly have individually purchased private insurance plans, more than any other age cohort. Over 17 percent had some form of public coverage, again, more than any other age cohort except for the over 65.

The major source of public insurance for the near elderly is Medicare. Individuals between the ages of 55 and 64 are more likely to have Medicare coverage because they are more likely to be disabled and qualify for Social Security disability insurance.

The near elderly were less likely to be uninsured in 1992 than any other non-elderly in the below 65 age group. Less than 13 percent of the population aged 55 to 64 were uninsured, compared with 14 percent for the 45- to 54-year-olds, and 18.5 percent for the 25- to 44-year-olds.

The higher rates of insurance coverage result from greater numbers of the near elderly purchasing individual coverage and the great eligibility for public coverage, particularly Medicare.

Although individuals between the ages of 55 and 64 are more likely to be covered by some form of health insurance, this is the only age cohort in which women are more likely than men to be uninsured. Women in this age cohort have a more tenuous attachment to the work force than men, and are more likely to lose it through divorce, death, or retirement of spouses. They are, thus, less likely to have access to group health insurance coverage, which is quite a bit cheaper than individually purchased coverage.

As the near elderly become less connected to the work place, either through their own separation or that of a spouse, the source of health insurance and the financial consequences of purchasing health insurance coverage change. Individual health policies are available to the near elderly, but indemnity plans are expensive and pre-paid plans may be unacceptable or unavailable.

Individual policies, under traditional health plans, may cost between $3,600 and $6,000 annually for an individual, while family policies may cost as much as $12,000 annually. These policies may not be available without medical underwriting, in which the applicant must undergo a physical before the policy is written and not have any pre-existing conditions.

Senator RIEGLE. Let me just stop you, too. As I recall, you were saying earlier, to the people in that group who are not working, I think you said the average income was about $20,000 annual income.

So, if you're talking about taking the figures of $3,500 or as much as $10,000 or $12,000 for a family policy for coverage out of

a total income that is maybe, on average, only $20,000, you are talking about a prohibitive cost, are you not?

Mr. CUSTER. Absolutely right. And it may not even be available at any cost, given the health needs of that particular individual.

Senator RIEGLE. Exactly. I mean, if there is a pre-existing condition, or somebody's got asthma, or diabetes, or what have you, presumably the insurance company screens them out. Would that not be the common practice?

Mr. CUSTER. Exactly right. And that is why the benefit of employment-sponsored coverage has been so great for those retirees who have had access to that.

Senator RIEGLE. Right. Because they've been able to be part of a large insurance pool, in effect, and so they have had the advantage of both the guaranteed access into the pool and the pool itself.

Mr. CUSTER. Exactly right.

Senator RIEGLE. It seems to me that with those numbers, and the fact that we know that group in our society is increasing—people are living longer, you are having more people who lose their jobs later in life and cannot get retracked, or have a health disability that gets in the way of that—that the system just does not work for them. The system is misdesigned.

It is designed, in effect, to leave them out there in a situation where they are highly vulnerable and cannot do anything about it, despite the fact that they will have worked, as Mr. McEntee said, for decades as productive workers in society; they basically just sort of fall off a cliff at this point as they wait for Medicare to kick in. But I think you are putting your finger on the problem. Let me let you continue.

Mr. CUSTER. Well, I was concluding my statement. I would be happy to take any further questions you might have.

Senator RIEGLE. Yes. Right. Is that it?

Mr. CUSTER. Yes, sir.

[The prepared statement of Mr. Custer appears in the appendix.]

Senator RIEGLE. Ms. Tanaka, we would like to hear from you next, please.

STATEMENT OF SUSAN TANAKA, VICE PRESIDENT AND DIRECTOR, HEALTH CARE PROJECT, THE COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET, WASHINGTON, DC

Ms. TANAKA. Thank you, Mr. Chairman, Senator, for the opportunity to appear before you today. My name is Susan Tanaka. I am the Vice President for The Committee For A Responsible Federal Budget.

We are a non-profit, bipartisan educational organization. We are committed to the task of educating the public about budget and fiscal policy issues. We believe that an informed public will make and support more informed public policy choices.

Let me start by saying that I am not a health care expert, I am a budgeteer. But that is appropriate, because the health care reform debate is largely a budget debate. It is about establishing priorities and allocating resources among competing interests. It is about raising the resources that we need to pay for the spending we want.

A hard part about the health care debate is not deciding what benefits we want. Without budgetary constraints we would want it all. But we do have limited resources, so we must reconcile what we want with what we are willing and able to pay for. This requires some very tough choices.

We want to increase access to health insurance, and, at the same time, control costs. The issues are complicated, but keeping in mind a few basic facts may help separate the forest from the trees when trying to decide what new benefits to provide.

Fact No. No matter how much money we spend, no matter what plan you enact, we cannot ensure eternal life. We cannot even buy good health. Bad things will still happen to good people. We do want more health care, but we are unwilling to pay the bill. Greedy doctors and insurance companies are not really the cause of rapidly increasing costs. We each are the problem.

Fact No. 2. People pay for health care, not employers and not government. We pay for health care in just three ways: through out-of-pocket expenditures, through foregone cash compensation when employers make contributions on our behalf for health insurance, and through taxes that support Federal, State, and local programs. Health care reform may change the amount of money flowing through each of these three channels, but we will still end up paying the entire bill one way or the other.

We might like to, but we cannot repeal the basic laws of economics. While it is more popular to talk about making employers pay, for example, for employees' coverage, the simple truth is that employees will eventually pay the bill, in foregone cash compensation or in lower real wages.

Since that is the case, hiding the cost through an employer mandate is counterproductive. It perpetuates the very myth that makes controlling health care costs so difficult, the myth that somebody else will pay the bills.

Adding new Federal subsidies for early retirees would not be free either. Those who continue to work would pay the bill. Under the President's broad community rating scheme, younger workers would pay twice; once, through significant cross subsidies to older workers, especially those between the ages of 55 and 64, and through additional taxes. The pre-retiree age group could receive triple subsidies. An estimated $2,000 a year in 1998 from community rating——

Senator ROCKEFELLER. Ms. Tanaka. Mr. Chairman, can I ask?

Senator RIEGLE. Yes, of course.

Senator ROCKEFELLER. Are you indicating that you do not think that younger people need to have health insurance? In other words, you are saying that they would have to pay more. It is sort of a pejorative tone in your voice.

Ms. TANAKA. No, Senator. What I am saying is, under a community rating structure we will obviously have cross subsidies between younger people to older people, and between healthier people to sicker people. That is the nature of insurance, and that is the nature of the community rating.

Senator ROCKEFELLER. Yes. But can you read the last sentence that you gave about young people? Could you just read it again, please?

Ms. TANAKA. I said, under the President's broad community rating scheme, younger workers would pay twice. Once, through the significant cross subsidies to older workers, particularly those between the ages of 55 and 64, and through additional taxes.

Senator ROCKEFELLER. And it is not any surprise, is it, that they would be paying more?

Ms. TANAKA. No. Because, as we know, health care costs increase with age.

Senator ROCKEFELLER. Right. And then you also agree that if people get health insurance when they are young, as they ought to, they will pay more in their earlier years and, thereby, pay less in their later years. Do you not agree with that?

Ms. TANAKA. Under a community rating scheme, that is what would happen. However, the problem is, we know that younger people earlier in their lives are earlier in their lifetime earnings stream, they have fewer assets, they have lower income. We are asking——

Senator ROCKEFELLER. So, what is your point for making that statement, that they should not have to get health insurance?

Ms. TANAKA. No, my point is not that they should not have to get health insurance. I have no problem with young people cross subsidizing older people if older people need it. I do question whether or not we really want younger people who may have lower incomes and fewer assets to cross subsidize older people simply because they are older. Under a community rating scheme there is no means testing.

Senator ROCKEFELLER. So then you would also, in the pejorative nature of your statement, question whether we should be doing community rating?

Ms. TANAKA. I would raise questions about whether or not we should do broad community rating without age bands, but it is an issue that is open for debate and it is one that I think——

Senator ROCKEFELLER. That is generous.

Ms. TANAKA. I'm sorry?

Senator ROCKEFELLER. That is generous of you. If a young woman who does not have health insurance gets pregnant, you realize, of course, that she, in most parts of our country, cannot get health insurance because pregnancy is considered a pre-existing condition.

Ms. TANAKA. I understand.

Senator ROCKEFELLER. Young women do get pregnant, do they not?

Ms. TANAKA. Yes they do.

Senator ROCKEFELLER. Yes. And that does not matter to you?

Ms. TANAKA. No, I am not saying that it does not matter.

Senator ROCKEFELLER. In other words, that a person who gets pregnant cannot get health insurance.

Ms. TANAKA. Senator, I am not making a value judgment, I am simply saying——

Senator ROCKEFELLER. No, you are making a value judgment.

Ms. TANAKA. No. I am simply pointing out the nature of insurance. In order for insurance to work, you have to have the risk spread over a broad population. Everybody's risks under health care are not exactly equal.

That means that, under one big pool, some people will end up winners and some people will end up losers in the current year. Obviously, over time, if the structure stays the same, those people who are, today, young, and eventually will be old, will benefit from that cross subsidy.

Senator ROCKEFELLER. So that in life, if all things were equal it would be best, in your view, if the young and old always had to do the same things. For example, we just finished the Persian Gulf War. If older people are, therefore, protecting younger people, that is considered societally not beneficial on your part. You think that five-year-olds ought to be sent to the Persian Gulf to fight?

Ms. TANAKA. No, Senator. I did not say that.

Senator ROCKEFELLER. I know you did not say it. But I am just trying to get your sense that life is only fair if everybody pays exactly the same or makes exactly the same sacrifices at all points in their life.

Ms. TANAKA. No, I did not say that either.

Senator ROCKEFELLER. I know. But that is what you are saying about health insurance.

Ms. TANAKA. No, I am not saying that about health insurance.

Senator ROCKEFELLER. All right. Then continue your testimony.

Ms. TANAKA. So the pre-retiree age group could receive up to three types of subsidies: $2,000 a year in 1998 from community rating; income-based individual subsidies as proposed by the President; and any additional Federal subsidies for early retirees.

Fact No. 3. We do ourselves no favors by hiding the cost of health care. We need a stronger consensus around the financing of health care benefits, as around the benefits themselves. If people do not acknowledge and understand the costs, they will be unable to accept the measures required to keep those benefits affordable.

Notably absent from the health care discussion, or at least not readily available to the public, are consistently priced line item cost estimates for specific benefits under Congressional consideration.

The fact that I spent many largely unsuccessful hours yesterday trying to understand the cost estimates for the early retiree benefits makes the point. It is difficult to make intelligent choices if we do not know how much it costs.

My auto insurance bill lays out the costs very clearly; so much for this level of collision coverage, so much for towing. I can decide whether I would rather increase my coverage or decrease my premium. And, if I drive carelessly and have an accident, the cost of the behavior is soon visible in the premiums I have to pay. People should have available the same type of information before we make up our minds about what package of health benefits health care reform should provide.

Congress and the President should tax finance those benefits that you deem to be national priorities. While individuals may disagree with the right level of funding for these activities, all Americans should help pay the bills.

Some activities, like national defense, are essential to all Americans and should be available without regard to individual circumstances. The country has reached the consensus that other Federal activities, like Medicaid and AFDC should be available to

those who need the help. Whether and where health care benefits fit within these categories is still under active public debate.

Consensus about the financing means being open and honest about where the money comes from. Call them whatever you like, but mandates are taxes. They would be compulsory. The resources would be used to finance Federally-designated purposes. If avoiding the word tax is——

Senator ROCKEFELLER. Mr. Chairman, can I interrupt again?

Senator RIEGLE. Go ahead.

Senator ROCKEFELLER. Ms. Tanaka, do you have a car?

Ms. TANAKA. Yes, I do.

Senator ROCKEFELLER. Do you pay auto insurance?

Ms. TANAKA. Yes, I do.

Senator ROCKEFELLER. You recognize that auto insurance is mandated by the State.

Ms. TANAKA. Yes, I do recognize that.

Senator ROCKEFELLER. And when you pay your auto insurance do you say, this is a tax, or do you say this is a premium?

Ms. TANAKA. I still have the choice, one, not to drive a car, and, two, to go out and choose the policy that best suits my purposes. I used to have an old car that was 10 years old, so I had very low collision coverage on it because if it got hit it was not going to be worth fixing. But I was allowed that choice.

Senator ROCKEFELLER. We are not talking about amounts, we are talking about the principle.

Ms. TANAKA. Well, what I was saying is——

Senator ROCKEFELLER. Would you consider auto insurance a premium or a tax?

Ms. TANAKA. I would not say that auto insurance premiums are taxes because they are different from the premium structure that is proposed, the mandate structure proposed under the Health Security Act.

Senator ROCKEFELLER. But you are saying that they are not a tax because the individual has the option not to have an automobile.

Ms. TANAKA. Yes.

Senator ROCKEFELLER. So that is your definition of why it is not a tax?

Ms. TANAKA. No. I also said that because I have a great deal of individual choice about exactly what kind of policy I want to get. I can choose to pay a higher deductible.

Senator ROCKEFELLER. No. That is irrelevant. I mean, that happens under the Health Security Act, too. But if you are working and you have to get to your job and it is more than 20 miles away, and you do not want to bicycle or hitchhike, you more or less have to have a car in this country, do you not? I mean, most people do.

Ms. TANAKA. Understood. And along with that comes——

Senator ROCKEFELLER. Your sense of having an option of not having a car is rhetoric as opposed to substance, is it not? You have a car.

Ms. TANAKA. I have a car.

Senator ROCKEFELLER. Yes.

Ms. TANAKA. I could be irresponsible and not purchase automobile insurance. I could break the law. But I choose to purchase insurance and——

Senator ROCKEFELLER. You are required to.

Ms. TANAKA. And I exceed the requirement——

Senator ROCKEFELLER. You are mandated to purchase insurance and you, therefore, do.

Ms. TANAKA. But my choice about coverage exceeds what I am mandated to purchase. I have a certain amount of latitude and decision about what kinds of coverage I would like to purchase.

Senator ROCKEFELLER. But you are mandated to do it by the State, are you not?

Ms. TANAKA. Absolutely. I do not disagree with you.

Senator ROCKEFELLER. Do you complain about that regularly to your neighbors?

Ms. TANAKA. No, I do not.

Senator ROCKEFELLER. That is good.

Senator RIEGLE. I think the whole question of auto insurance and the mandates that are presently there—I know the other day when I was getting my renewed annual registration and license plates for the two cars that we have in our family—and we do this in Michigan, of course—you cannot register your car and, therefore, get the license plate for the current year unless you give them an insurance certificate.

In other words, you have got to send in the registration fee, but with it has to come a notification from the insurance company that says, yes, this person has insurance and it is active and it is in force, otherwise, I cannot register my car and I cannot get a license plate.

I suppose I could if I wanted to—as you say, a person can sort of try to drive their car anyway and hope they do not get caught. But the fact of the matter is, we do lay down an iron requirement. I think the point is well taken. Is there some reason why we should be doing it in the area of automobile driving and coverage and not with health coverage? I mean, what is the fundamental distinction between the two?

I agree with Senator Rockefeller that, under the President's plan, there is a choice. You could get the policy with all the bells and whistles or you can get a basic policy that does not offer the same thing as a policy that has more. But, with respect to the concept of having to have it, what is the difference? I mean, you obviously see a difference in your mind, and it is escaping me, too.

Ms. TANAKA. Let me say that there is no clear line that we can draw that says, this is—well, I should try to state it a different way. As we look across the spectrum of potential requirements that the government imposes on us as individuals in income tax or payroll tax, I think we would agree that those are clearly taxes. They exist in law, we have to pay them, we do not have any choices, there are penalties if we do not pay them.

On the other end of the spectrum we have a whole host of other kinds of requirements the government imposes on us, including anti-pollution requirements, clean air requirements, auto insurance, Worker's Compensation, a lot of different kinds of require-

ments the government imposes on us which cause us to have to use our resources for that specific purpose.

What is different about the President's Health Security Act—and let me say that it is not all mandates, per se—is the specificity about the amount that has to be contributed, and if you believe that employees ultimately pay the bill, that what an employer contributes is part of total compensation, the amount the employer has to pay is not at all within the control of the individual. There is that 80 percent of an average premium that goes out the door, goes into the health alliance, and the individual has absolutely no choice about that.

So if I, as an individual, for whatever reason, wanted a different type of coverage that would imply a different rate other than that 80 percent of the average premium, I do not have any control over that.

That is what makes this particular mandate a tax. It is the inability to control the amount of resources, the requirement to purchase a certain kind of service, and the designation of where that money goes that is completely outside of individual choice. Does that help?

Senator ROCKEFELLER. No, of course not. I am just actually concerned, Mr. Chairman, because I think we are dealing with somebody who has an ideological bias here. But we are not discussing early retirees, which I think is what you really want us to talk about, and I apologize for getting off the subject.

Senator RIEGLE. Well, I think it is a relevant point. Hopefully, it illuminates this area of the health care issue.

But why do you not go ahead, Ms. Tanaka, and we will have you finish up here.

Ms. TANAKA. Thank you.

Fact No. 4. We cannot spend the same money twice. We cannot solve the budget deficit problem unless we solve the problem of growing health expenditures in the Federal budget. But the President's bill, and virtually all other health care reform proposals before you, would increase net Federal spending for health care. That means two things.

First, to ensure deficit neutrality you must raise taxes. And the added revenue you spend for health care will not be available to pay for education, housing, law enforcement, national defense, deficit reduction, or anything else that you might think is important.

Second, if you are satisfied with deficit neutrality, deficits in health care spending stay on the same unsustainable upward path. So, by the year 2004, health spending will take up over one-third of total Federal outlays and deficits will exceed $350 billion.

The current crop of health care reform proposals are projected——

Senator ROCKEFELLER. Mr. Chairman, can I just interrupt again?

Senator RIEGLE. Senator Rockefeller.

Senator ROCKEFELLER. I can see the look of anticipation and enthusiasm on your face as I proceed to disrupt this entire hearing.

Senator RIEGLE. I want to hear what you are going to say.

Senator ROCKEFELLER. Could I just ask, Ms. Tanaka, as you have done your calculations here, if we were not to pass health

care reform, has it occurred to you what health care costs might be in the same time frame that you are talking about?

Ms. TANAKA. For the Federal budget, or nationally?

Senator ROCKEFELLER. You can pick either one.

Ms. TANAKA. CBO says, if you look at national health spending under the President's plan, if the premium caps work, instead of 20 percent of GDP we will be spending 19 percent of GDP.

Senator ROCKEFELLER. So, what you are saying is, that if we do not do health care it will cost more than if we do do health care. Is that right?

Ms. TANAKA. It could. But there is——

Senator ROCKEFELLER. Is that not right?

Ms. TANAKA. The reason why I say it could is because it depends upon how much faith you place in the cost containment mechanisms that are included, not only in the President's bill, but in virtually every bill that is before you.

Senator ROCKEFELLER. But you are for a premium cap, are you not?

Ms. TANAKA. I would not take a position in favor of a premium cap.

Senator ROCKEFELLER. But you would have to be because of what you just said. I mean, you think costs are getting out of control. We have got to get all of these costs under control, and, therefore, it would be natural, unless you trust managed competition so utterly. You are such a logical person, it just seems to me that a premium cap would almost be a requirement in your thinking because you would want us to be able to control costs.

Ms. TANAKA. A premium cap is one approach to controlling costs. It happens to be the approach that is more scoreable from a budgeteer's perspective because it is written in law, you can see it, and you can calculate the difference between the baseline and the premium cap. That is a calculable cost.

Another approach to containing costs is managed competition. Both of these approaches are untried in the United States on the scale that we are talking about. There is some question about whether either approach is going to be 100 percent effective.

Senator ROCKEFELLER. So your conclusion, therefore, is to try the approach of managed competition, which has not been tried before, and have no fall-back position just in case it does not work.

Ms. TANAKA. No, Senator, I am not taking a position in favor or against either approach. What I am trying to say is that there are some very ambitious cost containment assumptions under either approach, and we do not really know exactly what kinds of costs we will incur as a result of any of these approaches or where the savings might materialize.

We are talking about $1 trillion worth of economic activity. We are talking about 250 million people in the country whose behavior will be affected. It is impossible to predict with great—with any—precision how much benefits will cost and how much we will save under any of these approaches.

So, my message is not that we do one or we do the other, my message is simply that if we make what we are doing visible, if the costs are clearly there——

Senator ROCKEFELLER. Your message is not that we cannot do one or the other. You just called premium caps horrible.

Ms. TANAKA. I am sorry?

Senator ROCKEFELLER. You just called premium caps horrible. So, your message is that you do not want to do premium caps, but you do want to do managed competition.

Ms. TANAKA. Senator, I do not think I called them horrible.

Senator ROCKEFELLER. I thought I heard you say that.

Ms. TANAKA. I am sorry. I did not call premium caps horrible, I called them "scoreable."

Senator ROCKEFELLER. Yes. Mr. Chairman, after careful consideration, I think that I am not being particularly helpful at this point and that the good lady ought to be able to continue her testimony.

Senator RIEGLE. Ms. Tanaka.

Ms. TANAKA. In any case, any proposal then that can claim to hold health care spending down to 19 percent of GDP does save money relative to the baseline trends. But the question is, do we really want to spend almost $1 out of every $5 anyone anywhere in the United States produces on health care? I do not know the answer. That is one that will be decided by you and by the public. But we should ask ourselves the question, is this good enough?

On the question of early retiree subsidies, as with any new Federal program or benefit, it is appropriate to ask ourselves a number of questions. Should we create another only minimally means tested entitlement?

Should we create incentives for early retirement just when we need more Americans to work longer, just as increased life expectancy and the resulting extension of retirement are putting incredible pressures on existing Federal entitlement programs?

Should we add to the tax burden of younger workers, many of whom have lower incomes and fewer assets than those whose health care they would be asked to support? And should we choose to expand Federal liabilities when we already cannot pay for the ones that we have and are passing on ever bigger bills to our own children?

The issue of federalizing health care benefits for early retirees should be resolved by asking, is this a national priority? How else might we spend the $3-5 billion a year? And, if you decide that it is a national priority, what kind of tax is most appropriate to pay the bills?

Finally, a word of caution. Because of the scope and magnitude of the issues you are addressing the financial risks to the Federal budget, as well as the rest of the economy, are great. The estimates of the budgetary impacts of health care reform will be wrong. Most proposals, not just the President's, are very specific about the benefits they promise, but they are very hazy about where the savings will come from.

While the scoreability of savings is greater for cost containment approaches like premium caps and global budgets than it is for things like managed competition, those savings are not necessarily more certain.

Based upon past perspective, we know that we tend to underestimate cost and overestimate savings and revenue. In the case of

health care reform, because we are talking about a trillion dollars in economic activity, there is a risk that our estimate will be wrong.

The whole health care debate is about sharing risks and shifting costs. The question, is whether the Federal Government should take on new liabilities and risks that we either cannot or will not pay for.

But there is some good news. The American people are not as dumb and selfish as some would have us believe. Based upon my travels around the country, conducting meetings that allow people to grapple with these very difficult issues, I conclude that, one, people are very much interested in understanding this issue and they know it is important; two, people can and will make responsible decisions when given the opportunity and sufficient information.

People are certainly smart enough to know that they are not getting all the information they need on health care reform and they are starting to feel frustrated and manipulated. Could this be contributing partially to the government's growing credibility problem? I do not know, but it is a question.

Thank you. I would be happy to answer any further questions you might have.

[The prepared statement of Ms. Tanaka appears in the appendix.]

Senator RIEGLE. I want to just pose one question to you, and then I want to go to our last witness. And this will be brief, because I do not want a long intervention here before we hear from Mr. Amsden.

Do you have in mind a time period, as a budget person, over which with any health care plan we should measure costs and benefits? And let me give you a context in which to answer the question.

When we put a form of comprehensive health care/ universal coverage type health care in place in Hawaii, for example, if you look at the cost and savings patterns over a period of time, it took about 10 years of the 20 years before the cost patterns really begin to change dramatically from national averages, so you can pick, you know, any time frame.

In a sense, we are stuck here in our budget calculations where we just take these five-year periods, and it looks to me if that is an artificial time period which is inherently not the right one to use when we are trying to evaluate the efficacy of any kind of an alternative health care plan, the effect of which, it looks to me, needs to be measured over a period of years longer than 5 years. Now, that does not make it easy to do. There are a lot of complications in the measurements, and whether we get them right, and so forth and so on. That is the context.

So, my question to you as a budget person is, if you were to try to take and make meaningful projections the best you could of a health care plan, what is the time period over which you think we ought to try to make that evaluation?

Ms. TANAKA. Well, I agree with you, at least 10 years. CBO is providing 10-year estimates on the health care reform proposals. The problem, of course, is the further out you go, the more tenuous

the estimates. So it is a trade-off between wanting to provide enough time——

Senator RIEGLE. Right.

Ms. TANAKA.—so you can realistically look at what the effects might be.

Senator RIEGLE. Right.

Ms. TANAKA. But the further out you go—and it is like anything else—the variance becomes greater.

Senator RIEGLE. Well, that is true. And side by side with that, it seems to me, you have got another element that is unique to health care. And that is, that if you have got a good health care plan that is working —in other words, preventive care getting into place for expectant mothers and for other people where you are hopefully avoiding certain illnesses, catching them early, correcting them earlier when they are less expensive to correct, that preventive care, over time, gives you cost savings that might accrue after, say, 10 years, whereas, if you do not have good preventive care, you obviously do not get the beneficial health effects later on down the line.

What I am struck by in the case of Hawaii, is it appears in the 20-year time span, that it took about 10 years before the long-term health benefits really began to kick in and materialize in terms of big cost savings.

The cost lines broke apart so that today the rest of the country is experiencing roughly a 14 percent rate of expense on health care as a percentage of the total economy, and Hawaii is down closer to 8 percent. So the two lines split apart, but it took 10 years to, in a sense, start to really accumulate sort of the savings or the unspent dollars in terms of a better health profile.

Now, I grant you, the further out in time you go the harder it is to make these estimates, and that is why I think the one experiment that we have has some value to you, not that we are going to be at the same starting point that Hawaii was 20 years ago.

But the difference in those percentages, to me, is striking enough that I think I can see, as a trained economist and as a trained finance person, a cost factor that is material that looks like it may take as long as 10 or 20 years to get to, and that if we are not making the most accurate assessment we can of that and back loading it into the calculation, that even OMB's 10-year calculation, or the budget process here, which is only 5 years, which is artificially shorter and even more distorting, does not necessarily help us very much.

Now, all of that leaves aside the suffering, the heartache, and the pain that goes with illnesses that we all can have, and if they are not tended to and people do not get the cure they need it is really a tragedy; a personal tragedy, and, I think, in a cumulative sense, a national tragedy.

But, leaving aside just the decency of wanting people to have their health needs met and problems avoided where they can be, I haven't been able to find a way to sort of lop off the second 10 years of the Hawaii experience given the degree to which it seems to widen out the comparative numbers.

And, if I do not do that as a budget person—I serve on the Budget Committee, too—and if we do not try to do some accurate job of

sort of looking at the second 10 years, I am not sure we are going to get this right. I think it does relate to this early retiree group, or this near elderly, is the phrase I think you used, Mr. Custer, today. I am in the group. I mean, I twinge a little bit when I hear that phrase.

But, as I look out across the country right now and I look at Michigan—I mean, Michigan has its own profile but other States are different. I am sure it is probably true in some respects, as the way I am going to say true, in West Virginia.

If you are out of a job and you are 57 or 58 years old and you do not have a skill mix where there are want ads in the paper saying, we need computer programmer to do X, Y or Z, you can be in a situation where nobody wants you. I mean, that you, in effect, are unemployable; there are not any jobs for you.

And there is no health insurance for you. The employer does not want you. The health insurance system, especially because you are starting to get into a category where you are going to likely have more health problems, and you may, in fact, have them, the health insurance system says, thanks anyway, we are really looking for the young person who is more healthy, presumably. And here they are. I mean, they are out there and right now many of them have no place to turn.

I suspect that what is going to happen is that, even on just an accounting financial eyeshade analysis, that if we do not see to it that that group has insurance in place with good preventive care and regular supervised care, that we are going to end up spending more for them than we will if we have an insurance plan in place.

So I do not think there is any laissez faire type strategy that is available to us that is not, at the end of the day, a more expensive strategy, which, as a budget person, causes me to say I cannot afford the most expensive approach, which is the approach that says we do not know what to do, so let us kind of leave the system alone.

And then we get the 20 percent that CBO is estimating as a percentage of cost of the economy in the year 2000. I think you are right. These numbers, if anything, tend to widen out. So if CBO says it is going to be 20 if you do nothing, maybe 24 percent. I mean, I do not have any confidence in the 20 percent, particularly, as an outside limit.

I guess I am having a hard time understanding why, as a budgeteer and as a finance person, which you are and I am, I gather, you are not persuaded by the notion that says, over time, a better health profile and a better insurance system underneath the people to get to that profile is, in the end, going to cost us less.

Ms. TANAKA. Well, Mr. Chairman, I may agree with you. You could do sort of a present value calculation, and many of the cost benefit analyses on prevention measures do exactly that. They go 14, 15, 20 years out, and they present value back; the anticipated gains from doing, say, immunizations. But, unfortunately, under the current——

Senator RIEGLE. Or prenatal care.

Ms. TANAKA. Prenatal care.

Senator RIEGLE. It seems to me that that is one that is a clear winner.

Ms. TANAKA. But, under the current budget rules, of course, you cannot do that kind of calculation. We have very specific budget rules under which you are currently forced to operate that do not allow you to do that kind of accounting.

Senator RIEGLE. But would it not be wise then to maybe set those aside for this kind of a problem? In other words, maybe we need a different set of budget rules on this problem because the problem is so different. I mean, I think the 5 years is artificially restrictive, do you not?

Ms. TANAKA. I agree with you, particularly with health care reform, that 5 years is simply not enough time. It just simply is not enough time, and there is some question about whether 10 years is an adequate period of time.

When you look at CBO's estimates for the President's plan, the further out you go, the smaller the impact on the deficit. That is specifically because if the caps work they would produce certain benefits for the economy and for the society. The further out you go, the more of those benefits you get under their modeling.

The problem is, as budgeteers we have tended to shy away from what might be called dynamic scorekeeping, trying to figure out and calculate what possibly could happen throughout the economy as a result of any single decision that the Federal Government makes.

Some might make the same argument for education as you are making for health care; that because we educate our people better today, they will be more productive 20 years from now, and we should somehow try and account for that benefit in our budget. Others are making that very same argument on GATT, that GATT will increase trade and, as a result of that, we will have all sorts of economic benefits.

So this whole issue of dynamic scorekeeping is very much under discussion. But budgeteers tend to be conservative, and if budgeteers err, they want to err on the side of having many resources rather than having not enough.

Senator RIEGLE. Yes. Let me just say one other thing. I asked the staff to go find out what defense spending is running roughly as a percentage of GDP, and I am told it is running at about 5.2 percent. I just want to use that as a benchmark to the 14 percent that we are spending on health care right now.

In a sense, on the external defense, or global defense, with the missiles, and the weapons, and the armed services, and so forth and so on, we are spending a little more than one-third as much as we are spending on our health defense, if you will.

In other words, all of our health expenditures to try to keep ourselves alive and healthy and so forth is a kind of defense spending, in my mind, at least. It is the essential purpose.

And, even in the education area, I do not know what that number is, but I would think that it is—I do not know that it is larger or smaller than defense. It is not as high as health care. Health care is an enormous chunk of the national economy. It is a strategy investment of a dimension that most people have not sort of tuned in on yet. This is a big number, and it is growing at the most rapid rate.

Yet, our public health, how healthy we are, is an enormously important issue. I mean, we love our families and our children and we want them well and healthy, but we need a healthy country. We need people who can get up and go to work every day and are not sick.

We need people who, once they are trained in a profession, then do not get sick for some reason and die and all of that capacity to produce and contribute and earn for the country and for themselves goes down the drain. I mean, there are very powerful economic arguments on behalf of why—and I think people are rational in their expenditures.

Why are we spending 14 percent on health care? We are spending it because people have decided that trying to stay healthy and stay alive is a very important thing to do. It is a lot more important at the end of the day than almost anything else you can think of, and that is why we are spending the resources that way at the present time. But I think that system can get out of control, as it clearly has, to the point where you are getting into a problem of economic consequence that is so much bigger than any individual decision.

And, if you do not see it in those terms and sort of capture the problem and sort of rationalize an answer to it in large, global terms, there is no way an individual, by themselves, can, unless you are lucky enough to be healthy all your life, or wealthy enough to be able to ride the system out, you know, positioned that way.

Most people are not. Most people are not going to have a perfect run until they are 93, and never go to the doctor, and never go to the hospital, and most people are not going to have the money to pay the bills.

And sometimes you can have the money, and, as I think you yourself said, you do not have enough money to overcome the problem. The problem takes you down anyway. Your child is stricken and dies, and it is a terrible tragedy, and no amount of money can change the outcome.

I am going to stop there because I want to go to our last witness, but I think we need to go to the longer time frame. I think we ought to be scoring this differently.

I think we ought to get out of the budget straightjacket of 5 years. I think that 10 years, in its own way, is just as arbitrary and constrictive as the 5 years is. I think, if anything, the Hawaii example, which does have value, tells us that probably something like a 20-year assessment seems to make the most sense. I am not sure that you can justify a time frame longer than that.

I would like to be designing this health care plan off those kinds of projections. I think we would be much more inclined to make wise decisions now than just an economic and financial point of view, if we were doing it that way. But we are not.

And, as a result, it tends to take and distort this discussion enormously. Unfortunately, the reason it is relevant to take the time to talk about it is the burden may come down heaviest on this group from 55 to 64 because they are a group that is out there right now who are vulnerable in different ways.

And, if you do not have a very sophisticated, encompassing view of the health care system that we need, it is very easy to miss this

group and end up not meeting their needs and end up costing the health care system a whole lot more in the end.

So we have a chance here to do two stupid things at once if we do not address this. One, is not meet the particular needs of this group whose health needs are rising, and, secondly, by the time we finally do we end up spending a whole lot more money than we need to, so that we have had the suffering and the waste of money. If we allow that to happen, we really need to have our heads examined.

I know you have got to leave, Mr. McEntee, soon. Mr. Amsden, why do you not go ahead, please?

STATEMENT OF PERRY AMSDEN, MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS, BREWER, ME

Mr. AMSDEN. Thank you, Senator Riegle. Good morning, Senator Rockefeller. I am Perry Amsden, a Member of the National Legislative Council of AARP, and we thank you for the opportunity to testify here today.

My written testimony discusses in detail the particular vulnerability of the 50- to 64-year-olds and the reforms AARP believes are critical for this group to achieve health security.

My oral testimony this morning is an overview of AARP's position, and, at the conclusion, I would like to share with you a couple of situations with which I am familiar.

About half of AARP's members are under age 65, and not typically eligible for Medicare. Many in this group face substantial problems in getting and keeping health insurance and in paying for health care costs that are not covered.

This pre-Medicare population is particularly vulnerable because they are less likely to have employer-paid health insurance than their younger counterparts and more likely to purchase coverage privately at very high rates. Please keep in mind that the average rate of retirement today is 61 years of age.

They are also more likely to have health conditions that force them to pay out-of-pocket costs two to three times the cost paid by younger populations. Many 50- to 64-year-olds are on fixed moderate to low incomes.

Older workers often face substantial barriers to working. As you have already cited, according to the U.S. Census Bureau, 38 percent, or eight million 55- to 64-year olds are not working.

Many of the so called "early retirees" have been laid off from their jobs or are looking, usually unsuccessfully, for a new job. They often face hiring discrimination, hardly due to the erroneous perception that they are less perception, and the reality that they typically have higher health costs. Some are forced to quit work due to health reasons.

Also among the 55- to 64-year-old non-workers, are women who have spent years in the home raising children and who find themselves widowed, divorced, or with a husband now eligible for Medicare. Only 35 percent of non-working 55- to 64-year-olds have coverage through their or their spouses current or former employers.

The picture is even more bleak for women in minorities, who are less likely to have retiree health benefits. Those with coverage

today could see it slip away tomorrow as employees cut back on benefits or eliminate coverage entirely.

As a result, about 20 percent of the non-working 55- to 64-year-olds are uninsured; another 10 percent must purchase coverage on their own. Moreover, of the eight million non-workers between 55 and 64, 34 percent have incomes less than 150 percent of the poverty threshold, and 55 percent have incomes less than 250 percent of the poverty threshold.

This vulnerable group faces three serious problems that health care reform must address. First, they face pre-existing condition exclusions and waiting periods that may deny them coverage at all.

AARP strongly supports requiring insurers to take all comers, regardless of health status, and prohibiting waiting periods. We are pleased that the debate in Congress has moved in that direction.

Second, this group faces premiums that are much too high because they are not community-rated or offered as part of a group rate. AARP strongly supports pure community rating. That is, charging all individuals or families in an area the same premium for the same benefits package, regardless of age, gender or health status. It is the way we used to do business in this country before insurance companies started cherry picking the healthiest groups.

We strongly encourage Congress to reject proposals that allow insurance companies to discriminate against older Americans by varying premiums based on age.

I would also note, because there is ample misunderstanding of this point, that age rating only applies to people under 65 years of age. The Medicare population is a separate risk pool.

Charging pre-Medicare persons higher premiums because of their age is similar to charging younger women higher premiums because they might have babies. There is no place in a reformed health care system for either of these discriminatory practices.

Some have suggested that insurers should be allowed to age rate premiums as a way to make higher income groups pay their share. AARP has long been an advocate of progressive financing in the health care system, but using age as a proxy for income is misguided and is not supported by the facts. Most of the so called early retirees have low or moderate incomes.

If Congress wants financing for health care to be based, in part, on income, then it should do so directly for everyone. Age rating premiums will not achieve that goal.

Third, this group does not have a sponsor to help pay the premium and not nearly enough income to pay for health premiums, even if they are community-rated. There is general agreement in this country that health insurance is simply much too expensive for individuals to afford. That is why many businesses pay for coverage today and why an employer mandate is so important to universal coverage. It is also why Medicare was enacted and why it continues as a very popular program today.

If we were to continue the employer-based system of health coverage, the non-working 55- to 64-year olds will need the same kinds of protection that workers and Medicare beneficiaries will have under a reformed health care system.

Particular attention should be given to low and moderate income individuals in this age group. AARP strongly supports proposed

Federal subsidies for non-workers with incomes up to 250 percent of the poverty level.

AARP is pleased that the President's early retiree proposal would provide health security to a very large number of this vulnerable age group. It is important to keep in mind that those who would benefit most from the proposal are those that currently have no health coverage at all.

AARP looks forward to working with the committee to realize the goal of universal coverage and ensure that 50- to 64-year-olds obtain equitable treatment in comprehensive health care reform legislation.

At this time, I would like to share with you a couple of stories.

Senator RIEGLE. Please do. I know you have got a couple of stories. After all, that is what we are here about, are people and not just numbers.

Mr. AMSDEN. All right. I have a neighbor who fits in this category age wise. He was a career employer of the Brewer Water District. A back injury forced him to have an operation. His physician encouraged him and recommended that he no longer continue to work with the rural water district because he was jeopardizing his future health.

I am not exactly sure of the details, whether it was Worker's Compensation or some other program that funded his two-year college experience, including previous college experience that he had had back in his earlier years, would prepare him to move into the field of business accounting.

Following his graduation, he then started submitting resumes, conducting interviews. That went on and on for months. He even volunteered in some situations and in some offices over a short period of time, hoping that this would give him an opportunity to be observed, and, at an opportune time, maybe fill the position.

Well, after about a year of searching for a job which was not available, a friend of his has given him a commission basis employment at a car dealership which, as he told me just this past weekend, was the toughest job he's ever done in his life.

He is very concerned about his future health insurance situation, but is realistic enough to know that even though he is still searching for employment, he still has to make his own determination as to whether he can financially support buying his own individual plan. So he would certainly fall within this category and would appreciate assistance.

The second situation is—and I come from the field of education and I am fairly familiar with what is going on in——

Senator RIEGLE. Excuse me. Is part of the inference on that story the fact that he is maybe not getting a position because people do not want to pick up the cost of insuring him as well?

Mr. AMSDEN. That may very well be, although they have never said that. I can well imagine.

The second situation is in the field of education in Maine. Budgets are being cut. School systems are facing serious problems of financing programs that have been in existence for years. Home economics programs, industrial arts programs that have been around for 60 years are now being flatly phased out; art and music as well.

I am familiar with a home economics teacher who, next week will be the last week of her employment because the program at the Home Economics Department is being completely phased out of that high school as a budget cutting situation.

She is divorced. She has two daughters in college. She will be paid and will have health insurance until the end of August, because that is the contract year. At that point in time she is really faced with serious difficulties because, in Maine, if you are a certified home economics teacher that is the only thing you can really teach, and you cannot find another job in another school district, even a neighboring school district, if the positions are being eliminated.

She might go for retraining at the college to become either an elementary teacher or perhaps something else in the secondary field, but obviously that is going to require a minimum of a year retraining.

Senator RIEGLE. Yes. And no guarantee she will do any better.

Mr. AMSDEN. And no guarantee that she will find a job at the end.

Senator RIEGLE. Yes.

Mr. AMSDEN. I can tell you very honestly that she is extremely concerned as to what her future is, and health.

Mr. AMSDEN. Well, and these kinds of problems will destroy your health. I mean, you can have fairly decent health, but if you want to make somebody sick, put them in a situation with stress like this and circumstances they cannot handle, and anxiety, and I have seen it a thousand times.

If you want to design a program to make somebody sick, put them in a situation where they are not able to cope despite their best efforts and you are almost certain you are going to see health problems. I mean, one follows the other. That is one of the great ironies of this.

That is part of why it is so inexcusably cruel for us to be so stupid as to not fix the obvious defects in this system so that people who are producing and have produced and who need to be able to protect themselves and provide their own medical defense, if you will, are in a position to do so.

I mean, to me it is very analogous to driving down the highway and coming upon the scene of the accident and people by the side of the road that have just been injured. Do we stop and help them or do we just drive on by?

Right now, we are driving on by people like the teacher, who is the home economics teacher that has lost her job, and has two daughters in college, and is divorced, and is not in a position to finance her own health care going forward into the future, and we are going to either drive on by her problem or we stop and we figure out what we do about it because we are a decent—hopefully—country and these things matter.

We want her to not be in a situation where health deteriorates because, in effect, we have sort of said, you know, you really do not count anymore in the scheme of things and we have got no place for you.

Mr. AMSDEN. I can assure you, she is extremely stressed this week because her future is very bleak.

Senator RIEGLE. Sure.

Mr. AMSDEN. And if you stop and think about the situation, sir, three to 5 years ago, even 2 years ago, she never dreamed that this situation would have occurred to her at this stage in her life. She thought she was probably there till full retirement.

Senator RIEGLE. Sure. Well, there are a lot of people like that. They are all over the State of Michigan and out of every conceivable area of work; talents all across the board, people that served in war time, done all kinds of incredible things for the country, and basically they cannot understand why the country is just driving on by right now and not stopping to help figure out an answer that can accommodate their situation.

[The prepared statement of Mr. Amsden appears in the appendix.]

Senator RIEGLE. Mr. McEntee, let me ask you this question. I know you must go. But there are other alternatives in addition to what President Clinton has suggested for dealing with this problem, are there not? What would some of the other alternatives be?

Mr. MCENTEE. Well, the President, as I understand it, has looked at the 80/20 split. I guess it was Congressman Levin that has come up with an income situation, something like four percent. I think that is something that Senator Moynihan looked at, not for early retirees, because, once again, he disregarded them in his mark.

And, as I said before, I would really like to underscore that we are extremely disappointed in that. I think eight million Americans are, as well. But he gave that benefit to small businesses, but not to early retirees in his mark, as we understand it. I think that is something you can look at, not necessarily an 80/20, but maybe it's an income situation and the figure of four percent has been dealt with.

The threshold, too, as we understand it, in terms of President Clinton's plan, is something like $90,000, or, for a two-member family, $150,000 or $130,000, something like that, and maybe that threshold could be lower. So, there are a number of options, and right now the 80/20 looks to be the best to us, but our mind is not closed.

Can I also make a comment, Mr. Chairman?

Senator RIEGLE. Sure. Please do.

Mr. MCENTEE. As the gentleman from AARP was making his remarks about these individuals that have been hurt by a system that they worked very hard and helped to make in this country, and as I mentioned in our testimony in New York City, the Chairman is intimately familiar with the downsizing that has happened in the automobile industry, and the steel industry, and a lot of our major basic industries in this country.

I would submit that that would not have been possible, that we would have had some street revolutions in Detroit, and Dearborn, Pittsburgh, and the Mawn Valley in Pennsylvania if there had not been health care for these people that literally had to leave those jobs to streamline and right size, or whatever you want to call the naming of that new industrial make-up.

I took part in some negotiations in the City of Philadelphia when Mayor Ryndell, a Democrat, became mayor for the first time. The

city was in some fiscal jeopardy and our union had helped them when they almost went belly up with Mayor Wilson Goode about a year before Ryndell by the utilization of our pension monies to help buy some bonds, to bring the banks into the market, to buy some additional bonds to literally meet the city payroll.

And those negotiations with Ryndell and the retirees right in this age group received health care from the city and health care contributions. The Mayor and his administration took the position, well, we have got to save money and we are going to have to drop that benefit. And these are people that were out there already that were enjoying the benefits and people that were looking at early retirement, because he was downsizing the city.

And the idea was one of, well, you know, they do not vote on the union contract so you do not have to worry about them. They are already retired and we have got to save some money. These are the people who helped build that city, ripped down that Chinese wall and made it the kind of city that it is today. They walked out of that city with an understanding that they were going to have this kind of benefit.

And, in the middle of those later years, you talk about stress, I mean, somebody getting the benefit and then to be taken away from them 6 months or 7 months later—we are in the position now where the union is paying the contribution for those kinds of people in the city.

The Senator from West Virginia has had intimate relationships and problems in terms of the mining industry quite similar, and the same kind of cases. And I would say to the Senate of the United States, I mean, do not forget them.

Senator RIEGLE. Yes. Well, it is sort of ironic that we would—in a sense we have just had these stirring and appropriate tributes to people who fought in World War II. We are celebrating the 50th anniversary of that extraordinary effort, and why we went and did it, and why so many people died in the process and left arms, and legs, and parts of themselves over there to do this. It was not just to liberate those countries, it was to stand for some things about what democracy is all about and what life should be like for people.

And, in fact, one of the great ironies is that we have got people in wars since that time that have gone out and given the same service who are right in this dilemma. And the country has the question of, who is the country, what is the country if it is not the people, and the people that have sort of made it all happen? If there is not some sort of sacred bond that we really have one to the other, I mean, I am not sure what the country is.

It gets a little hollow when we do all the ceremonial things if, when it comes right down to the question of what is happening in people's lives, we are driving on by when somebody is there by the side of the road in a desperate situation that they cannot handle by themselves.

Mr. MCENTEE. It is quite ironic, too, that the countries that we liberated all have it.

Senator RIEGLE. And we have helped pay for it by the tremendous generosity of our country.

Mr. MCENTEE. Sure.

Senator RIEGLE. I mean, the Marshall plan, and getting those countries back on their feet has really been a central part of their ability to sort of get clicking so that they can provide health care for their people. So it is a little ironic that they have it and we do not.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman. I want to actually just start by saying, it would be my guess that this is the last hearing that you will Chair, after many, many years in the U.S. Congress, and that makes me very sad.

I was just having a conversation with your excellent health legislative assistant. In the earlier part of your questioning when you were being sort of an econometric economist and I said, well, that is not my Don Riegle. Then you started ripping into the unfairness of the situation, the beautiful analogy of driving by people injured by the side of the road and just going right on and comparing them to the early retirees, and you started to get mad and you started pouring things out, and that is my Don Riegle.

You and I have sat together in the Finance Committee, now, for—the 7 years that I have been on it, you have been on it longer. No, we have been on, I guess, the same amount of time. In any event, I think that people like you getting out of here is bad for this institution. I think what this institution needs is a soul and what it needs is people who are not only trained as you are, highly trained, IBM trained and all the rest of it. But you just care passionately about people and their lives. You do it 24 hours a day. You wear it on your sleeve and it comes out in every single statement you make. It affects every cause that you attach yourself to.

There are no Democrats and no Republicans here, and very few people, but, to those who are, I would like to say that this, to me, is a very sad moment because I think you are a great U.S. Senator. I am not only going to miss you, but I think that this place is going to be substantially worse off because you will not be here. And I will do my best to try to make up some of the difference.

Mr. MCENTEE. Hear! Hear!

[Applause.]

Senator RIEGLE. Well, thank you. Thank you very much, Senator Rockefeller. I am deeply touched by your comments. I think in the soul department, you know, you bring an enormous amount, and beneficially so for the country and for the Senate.

I hope we never get to the point where this place becomes so mechanical that we sort of forget what it is all about, and that is really to help people, which is what, really, life is all about. I mean, we are here for one reason when it comes right down to it, and that is to, along the way, see if we cannot help other people who need our help and can benefit from our help.

I will be looking to you for some real leadership here. You are giving it now, and you will give even more in the future.

Senator ROCKEFELLER. Well, you will get more.

Senator RIEGLE. And we will be back to help. I am not disappearing. I am going back to Michigan, but I intend to raise a little hell out there, too.

Senator ROCKEFELLER. That is good.

I have a couple of questions, if I might, Mr. Chairman.

Senator RIEGLE. Please.

Senator ROCKEFELLER. I do not like saying nice things about you in public. You understand that.

Senator RIEGLE. Well, I appreciate it very much. I am very touched by it.

Senator ROCKEFELLER. Mr. McEntee, you are quite correct. Senator Riegle and I actually Chair the two subcommittees that have to do with health care on the Finance Committee, and we take our work very seriously. We work very hard at it and care very much about it.

And, at 3:49 p.m. yesterday, the Chairman's mark was printed and Senator Riegle and I were entirely strangers to it, as were all the others on the Democratic side and on the Republican side.

You are quite right that early retirees, the question was raised yesterday at the meeting, are they included. The answer was, no, they are not.

It is also true that in this mark which, oddly, in the paper this morning was referred to being very close to what the President's plan was. This comes of something of a surprise to me—they had something called a modified community rating, in which they adjust for age. And it was my prayer, and battle, and hope, that that would not happen, age-adjusted community rating.

Now, I would like you to describe what that does to the people that you care about, as well as the people that you represent, when you have (1) no early retiree program and (2) age adjusting on community rating, which means that those precise 55- to 65-year-olds will be paying substantially more than they would if we had pure community rating, which is, of course, what we ought to have.

Mr. MCENTEE. I say this with respect in terms of the Chair of the Senate Finance Committee, by doing both things within 25 minutes late yesterday afternoon, he has graded these seniors, these people who have given so much of their lives to this community and to the United States, as the lowest of the low in terms of consideration of people under national health care, and I think it is a disgrace. It will not work and it will hurt. It will be a disaster.

Senator ROCKEFELLER. The modified community rating proposal, as I see it, is the Chafee proposal. It certainly is not the Clinton proposal. It is said by those who oppose early retirees being included that only about 4 percent of corporations offer—Am I right, incidentally, in saying that—You may have had this in your testimony, and I came in late.

Mr. MCENTEE. I think the Chairman said it, and we said it as well.

Senator ROCKEFELLER. Yes. All right.

So you have this enormous group. Then you have it added onto enormously by downsizing. How can anybody miss that over the last 5 years?

I often ask people, what percentage of the work force in West Virginia do you think are coal miners? And I asked someone who is a pretty good friend, who is pretty knowledgeable, that yesterday, and they said 25 percent. I said, "Wrong; 4.5 percent."

Mr. MCENTEE. Sure.

Senator ROCKEFELLER. Now, these people have all been replaced by machines. They are all in their 40's, and 50's, and 60's, and they have all spent 20, 30 or 40 years working in the mines and they are out flat in the cold and they have no health insurance whatsoever. It is a wonderful way to treat people. Just an absolutely wonderful way to treat people, is it not? So what we have is that situation.

On the other hand, the critics then come back and say, well, what do you mean? These are all very wealthy people we are talking about. I would like to have you respond to that, these people that we are choosing, evidently so far, to ignore, and ignore in our Democratic party, which is even more tragic. Could you sort of give me a little bit more sense of that profile?

Mr. MCENTEE. Well, we provided in the testimony that the vast majority of these people that we are talking about are minorities; they are African-Americans, they are women; vast, vast majorities of these people.

As you are well aware, in the coal industry, the United Mine Workers of America, who, at one point, were a couple hundred thousand members are down now to about 35,000 working miners. The people that are out there now on retirement have no place to go. There are not any jobs in West Virginia. You know that as well as I do.

I come from Pennsylvania. In the 1970's, the United Steel Workers of America had 1.4 million members. They now have 400,000 members. You come from the State of Michigan. You always hear about the UAW, and, in the same sentence you always hear the UAW and Chrysler, Ford, and General Motors. The largest local union in the UAW today is a public employees' union. They are the State employees in Michigan.

The UAW used to be about 1.3 million; they are about 800,000. They are not rich people. They are the people who put the country together, but they are not rich people. They are the people that are being affected by this, the downsizing, or the right sizing, or the upsizing is not over.

We are now getting repeat performances time and time again in the public sector as this idea of redesigning or reinventing government comes to the fore. To take the existing Democrat administration, within four or 5 years they are going to reduce the Federal work force by 250,000 people. The redesigning government movement—and there is some good to it, there is no question about that—is all about a comprehensive plan to right size Federal Government, State, and local government.

This is what has happened, to a large degree, in all of our basic industries in the United States and it is going to mean smaller government for the delivery of public services and it means that people now working in the public sector, as akin to their brothers and sisters in the private sector, are going to have this effect of downsizing and right sizing. And, if they are not taken care of in terms of some kind of health coverage, I mean, what happens to those people?

And I heard earlier that the median income that they were talking about was something like $20,000 for these people, while for public sector workers it is $16,000. And you cannot go out and buy

a health care plan and keep the family together, and you cannot get a job at 55, or 57, or 59, so the car is going by as they stand on the road.

Senator ROCKEFELLER. Thank you.

Senator RIEGLE. Well, if I may just interject for a minute, if you take that home economics teacher up in Maine that is in that situation, she is not only not getting a response, but the kids are not getting home economics either.

I mean, this downsizing and right sizing, we are right sizing kids out of home economics training, and wood shop, and metal shop, and the other kinds of things that I think have a value and they have sort of stood the test of time, but it seems to me like we are shaving away a lot of the things in the name of whatever that we really need.

Mr. AMSDEN. To some extent it is going back to what some would call the basics.

Senator ROCKEFELLER. Mr. Chairman, it is my understanding that three-quarters of all of the people that we are talking about, the early retirees, have incomes of less than $25,000.

Mr. MCENTEE. Yes, that is correct. Sure.

Senator ROCKEFELLER. Of the uninsured. I am sorry.

Mr. MCENTEE. No, not of just the uninsured. Three-quarters of all non-working couples aged 55-64 have family incomes below $25,000.

Senator ROCKEFELLER. I mean, that is academic. Another charge which is brought by those who do not favor this is that this is some kind of a bonanza for certain industries, or that it is a bail out. And I am quite aware that there is an anti-windfall provision in this, I would very much appreciate if you could take that on and smash it into the ground.

Mr. MCENTEE. Well, we obviously do not think it is a windfall. It is transitory. It happens over a period of time. First of all, in terms of the workers, when you talk about a windfall for the industry, these workers—and, say, the Big Three or wherever it has happened, and it has happened all across the country—have gone to the collective bargaining table and they have taken zero wage increases, or 1 percents, or 2 percents in order to retain their health care benefits and in order to retain the benefits for the retirees.

And, as a matter of fact, in the last negotiations in the Big Three, and particularly with General Motors, it was the key issue of all, retaining these benefits for the retirees who built all these systems that work in America and now are as competitive as the Japanese.

And to take away a benefit from these workers is no windfall. I mean, these workers actually fought with the industry to get these kinds of benefits. They provided them. Now some money will go back into those industries, but only on a transitory time.

But the industries better be placed on record that the American worker has been screwed for the last 12 years and they are going to be back to the collective bargaining table trying to get some decent money because, for the last 10, 11, 12 years, even though inflation has been low, they have not even been able to keep up. So, it is not a windfall, it is an evening out of the turf, and it also will be, we believe, tremendously helpful to the workers.

Senator ROCKEFELLER. I really think age adjusting is an enormous factor. I think age adjusting takes the leaving out of the early retiree, which is bad enough in itself, and makes it a double whammy. It is a real double whammy. Ms. Tanaka may not agree with that. Would you care to express your views on that?

Mr. MCENTEE. Would you repeat that? Go ahead. Let me hear that again.

Senator ROCKEFELLER. In other words, these people 55 to 65 years old helped build this country.

Mr. MCENTEE. Yes.

Senator ROCKEFELLER. And Ms. Tanaka was saying earlier about, that it is not fair for younger people to have to pay for older people. We have just come through the celebration of the Normandy beach invasion, and I suppose you could, if you really stretched your thinking, make a case that some of these older folks have done something fairly decent for young people.

Mr. MCENTEE. Sure.

Senator ROCKEFELLER. Some of them died for it.

Mr. MCENTEE. Sure.

Senator ROCKEFELLER. But, in other words, they are getting hit twice in this plan.

Mr. MCENTEE. Sure they are.

Senator ROCKEFELLER. One, there is no early retiree provision, and, second, the community rating, which the President wants to be pure and ought to be pure, and, I hope, will be pure—in fact, I think, will be pure by the time we are finished with it. Nevertheless, right now, it is age-adjusted which ratchets up if those people without work, without health insurance, without prospect of getting a job.

Mr. MCENTEE. Right.

Senator ROCKEFELLER. And, as you say, there are no prospects. There is no 55, 57, or 62-year-old who can go and get a job in West Virginia today. It just will not happen. It will not happen.

Mr. MCENTEE. That is correct.

Senator ROCKEFELLER. Three-quarters of them have incomes of less than $25,000, they have no insurance and they have no job. So, now they are helped by their Federal Government doing health insurance reform by saying, one, there is no early retiree——

Mr. MCENTEE. Sure.

Senator ROCKEFELLER.—and, second, when we go to community rating, we are going to age adjust. So that if, having no health insurance, you want to go out and buy some, good luck. By the way, you are going to have to pay a much higher rate for the health insurance that you do get because it is age adjusted. That is a double whammy, in my judgment.

Mr. MCENTEE. Yes. Well, it is more than that, it is three strikes and you are out for these people. I mean, once again, the entire Federal highway system was built—these are all the people in that age group that built that Federal highway system. I think the way they have been treated, particularly in Senator Moynihan's mark, they have been treated like they never even existed in this country.

And I am not an economist, but let me also say this. I mean, I thought that the President's program, and I thought that, at least a stalwart fact of the Democratic party was that at least as a start-

ing point in meaningful national health care reform, that we were going to have universal coverage. I thought that was sort of a tenet of the Democratic party. I thought they stood for that for some 40 years.

I do not see how you have universal coverage and you do not cover these people. The argument in terms of the young and the old, I mean, that is the argument we have heard from the 1930's in terms of Social Security. That seems to be, if any system is working in the United States.

And, if you look at any poll, the Social Security system is the workable system that people look to, and that still carries what you would consider younger folks paying so that older folks can have a more decent life for what they contributed to this country. It is what the Senator said in terms of trying to help people along the way and, in this respect, it is trying to help people that gave so much to this country.

These young people would not have been in those public schools across the United States if the senior people, and the retiree people, and the people between 55 and 64 had not paid their taxes, had not gone to work and played by the rules, as the President said. Those schools would not even exist in terms of younger people. The education process in this country would not exist.

I would also say—and let me get back to the fact that I am not an economist—it would seem to me if we do not cover early retirees and we talk about all of this number, we have got some 37 million people that are not covered by health care, yet we know that they get some kind of health care, but they end up getting the most expensive kind of health care by going into the emergency ward and then working their way through the system.

Now, are we going to put eight million people, first of all, in the kind of human condition that they have to go in through the emergency ward for this kind of benefit after all they have given and have come to expect, and even demand this kind of benefit?

And then, if we do it, I think in terms of cost containment it is a negative. I mean, it is a negative cost containment if we do not cover these people. And I am not going into technical figures, or anything else, but we have 350,000 people working in the health care industry, and that is what they say. But I am not an economist.

Senator RIEGLE. You know, it is interesting. You make the point about Social Security and this tying the generations together, and we think of it principally as a retirement benefit for people who reach that age.

But, in the Social Security, part of the genius of it is that we also have a disability benefit for young workers. So, if a worker is 24 years old and on the way home from work today in a car or on a motorcycle and has an accident and is disabled and cannot provide for his family, say, or it could happen to a woman worker as well, there is a Society Security disability benefit that kicks in that takes care of that younger worker, so that, in fact, even in the Social Security system this intergenerational things is not a one-way street, it is a two-way street, as it should be. We have got to make sure that in the health care system that we have got this two-way street. That is why the community rating issue is so fundamental.

I mean, you have got to have everybody tied together here. Why is the newborn infant in the family anymore important than the grand-dad in the family, or the father, or the aunt, or the uncle? I mean, we are all those things.

You can add up the 250 million of us, and we all fit in the American family structure somewhere around that circle. I want a plan that sort of takes care of everybody, that responds to everybody's needs and not says that we will get some and not the rest. I do not understand that.

Mr. MCENTEE. Yes.

Senator RIEGLE. That is like taking a pair of scissors and cutting out part of the country.

Mr. MCENTEE. Yes. I probably do not have it right, but, in terms of the philosophy, I could not agree more the way Hubert Humphrey used to put it, that the mark of a society is how it takes care of its young, its sick, and its old. And that is what I think the Democrats and Republicans should be all about in national health care reform.

Senator RIEGLE. Well, thank you very much, all of you, for coming today and for contributing to this discussion.

I want to just say that Senator Mitchell has a statement that he wants to submit for the record, and I ask unanimous consent that it be entered here.

[The prepared statement of Senator Mitchell appears in the appendix.]

Senator RIEGLE. And, also, I want to say to Debbie Chang and to Mike Doonan, particularly, how much I really appreciate the tremendous effort that has gone into getting this hearing ready.

The committee stands in recess.

[Whereupon, at 12:06 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF PERRY AMSDEN

Good morning. I am Perry Amsden, a member of the National Legislative Council of the American Association of Retired Persons (AARP). Thank you for inviting me to testify on the health coverage problems of the 50–64 year-old population and for the opportunity to speak with the Committee on how the needs of this age group might best be addressed in health care reform legislation.

About half of AARP's members are under age 65 and not typically eligible for Medicare. Many in this group face substantial problems in getting and keeping health insurance and in paying for health care costs that are not covered. This "pre-Medicare" population is particularly vulnerable because they are less likely to have employer-paid health insurance than their younger counterparts and more likely to purchase coverage privately at very high rates. Please keep in mind that the average age of retirement today is 61 years of age. They are also more likely to have health conditions that force them to pay out-of-pocket costs two to three times the costs paid by younger populations. Many 50–64 year-olds are on fixed, moderate to low incomes.

AAAP hears from our quite vocal, younger members every day that they want and need comprehensive health care reform. We hear from workers laid off from their jobs and unable to buy affordable health insurance because of their age. We hear from Medicare beneficiaries whose spouses are not yet eligible for Medicare and must try to buy insurance on their own. We hear from mid-life women who, in order to care for parents with long-term care needs, quit their jobs or work part-time and, as a consequence, lose their health insurance. Not surprisingly, 50–64 year-olds are more critical of the U.S. health care system than any other age group (see Chart 1).[1] In addition, more than 40 percent of insured 50–64 year olds believe that the quality of their health coverage will decline in the future or that they will lose coverage entirely (see Chart 2).[2]

AARP AND COMPREHENSIVE HEALTH CARE REFORM

AAAP is committed to enactment of comprehensive health care reform in 1994. Reform must include:

- universal coverage so that every American can afford care and so that costs are not continuously shifted among providers, insurers, and businesses seeking to reduce their burden;
- a comprehensive defined benefits package for all Americans that includes prescription drugs and long-term care;
- strong cost containment measures in the public and private sectors that make health care costs more affordable for all Americans; and
- financing that is shared fairly among government, businesses, and individuals so that universal coverage will not become an empty promise as families find health premiums increasingly unaffordable.

AARP will continue to work with members of Congress, on a bipartisan basis, to help enact a bill that can achieve these objectives.

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[1] DYG, Inc. "Health Care Reform: Where The Public Stands" for the American Association of Retired Persons Department of Federal Affairs, May 1993.

[2] Sofaer, Shoshanna and Jean Johnson. "Health Insurance Access Among Near Elderly Americans." Draft Report to the American Association of Retired Persons' Public Policy Institute, February 1994.

PROFILE OF THE 55–64 YEAR OLD POPULATION

While AARP membership begins at age 50 and there are many 50 year-olds with health coverage problems, most of the focus in the health care reform debate has been on the 55–64 year-old population. Of the 21.2 million Americans age 55 through 64 in 1992, only half of them worked full time (see Chart 3).[3] Thirteen percent worked part-time, and 38 percent (or 8 million Americans) were not working:

Who are these people who are not working, and why are they not working? Too often the simplistic and frequently inaccurate label "early retiree" is applied. Many of these so-called "early retirees" have been laid off from their jobs or are looking—usually unsuccessfully—for a new job. In fact, three-fourths of the unemployed in this age group have experienced job loss or layoff. It takes them 50 percent longer to find a job than any other age group, and, if they are over 60, they are only half as likely to get any job. Indeed, many simply leave the labor force or find part-time work. Despite the Age Discrimination in Employment Act, hiring discrimination against older persons is prevalent, partly due to the erroneous perception that they are less productive and the reality that they typically have higher health costs. In addition, many Americans in this age group are not working due to 3health reasons. Also among the 55–64 year-old non-workers are women who have spent years in the home raising children and who find themselves widowed, divorced, or with a husband now eligible for Medicare.

Most of this "pre-Medicare" population have low or moderate incomes. Of the 8 million non-workers between 55 and 64, 34 percent have incomes less than 150 percent of the poverty threshold.[4] Fifty-five percent (or 4.4 million individuals) have incomes less than 250 percent of the poverty threshold.

Of the entire 55–64 year-old population, 3.4 million are uninsured. And most troubling, *about 60 percent of uninsured 50–64 year-olds report being without coverage for at least 5 years* (see Chart 4).[5]

For working 55–64 year-olds who are uninsured or at risk of losing coverage, the President's proposal requiring all employers to contribute to the cost of coverage would go a long way toward addressing their health care needs. Since most Americans currently get their health coverage through their employer, this is not a revolutionary concept. The reasonable concern that an employer mandate could lead to job loss in the short term must be balanced against the fact that our current health care system contributes to job loss and other serious work force problems. AARP believes that concerns about impact on small businesses ought to be remedied through careful phase-in of employer obligations, with "circuit breakers" available during that phase-in to avoid economic peril for individual employers.

Of course, the millions of 55–64 year-olds who do not work or work only part-time are much more likely than their full-time working counterparts to be uninsured. Twenty-two percent of part-time workers in this age group were uninsured in 1992.[6] Of the 8 million 55–64 year-olds not working at all, 1.5 million or 19 percent were uninsured in 1992. Enacting an employer mandate for current workers will not solve the coverage problems of non-workers. Other solutions are obviously needed.

Where Do Non-Working 55–64 Year Olds Get Their Health Coverage? "Early retirees" are 16 times more likely to be insured if health coverage is available from a former employer than if it is not.[7] That's good news today for those who are fortunate enough to have retiree health benefits, but only about 35 percent of non-working 55–64 year olds have coverage through their or their spouse's current or former employers (see Chart 5).[8]

Moreover, only 29 percent of female retirees and only 26 percent of non-white retirees under age 65 received retiree health benefits from their employer.[9] The General Accounting Office (GAO) estimates that 96 percent of America's businesses offer no health benefits to retirees.

Those with retiree health care coverage today could see it slip away as employers cut back on benefits or require retirees to pay higher premiums or copayments. Indeed, a recent Foster-Higgins study found that about half of all firms surveyed reported cutbacks or planned cutbacks. While retirees have often brought suit to protect their benefits, the courts have generally permitted employers to alter or eliminate coverage.

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[3] U.S. Bureau of the Census, Current Population Survey (CPS), March 1993.
[4] U.S. Census, CPS, March 1993.
[5] Sofaer.
[6] U.S. Census, CPS, March 1993.
[7] Sofaer.
[8] U.S. Census, CPS, March 1993.
[9] U.S. Department of Labor, "Trends in Health Benefits," 1993.

Non-working 55–64 year-olds who do not have coverage from their own or their spouse's former employer get coverage from four major sources:[10]

- Medicare—1.1 million or 13.6 percent
- Medicaid—1.07 million or 13.4 percent
- CHAMPUS, VA—0.6 million or 7.4 percent
- Other private—0.9 million or 11.5 percent

This still leaves *19 percent of non-working 55–64 year olds without any health coverage at all.*

More than 30 percent of non-working 55–64 year olds are either uninsured or must purchase coverage on their own. This vulnerable group faces three serious problems that health care reform must address:

- pre-existing condition exclusions and waiting periods that may deny them coverage at all;
- premiums that are much too high because they are not community-rated or offered as part of a group rate; and
- no "sponsor" to help pay the premium and not nearly enough income to pay for health premiums, even if they are community-rated.

OUT-OF-POCKET HEALTH COSTS ARE HIGH

Not only do older persons typically pay higher premiums for their health coverage than younger groups, but they also have much higher out-of-pocket costs for deductibles, copayments, and services not covered. In 1987, 50–64 year olds spent 80 percent more out-off-pocket per person on cost sharing (excluding premiums) than did the 24–44 year old group (see Chart 6).[11] As a percentage of family income, the average 50–64 year old spent 2.3 times more in out-of-pocket costs than the average 24–44 year old. In 1994, average out-of-pocket costs for non-working 55–64 year olds were about $1,200.[12] These estimates do not include the enormous cost of long-term care, for which very few Americans have coverage. Many 55–64 year olds bear the costs of their own or their parents' care in nursing homes and community-based settings.

NEED FOR ELIMINATING PRE-EXISTING CONDITIONS EXCLUSIONS AND WAITING PERIODS

As a result of poorer health status, 55–64 year-olds are more likely than their younger counterparts to have pre-existing conditions that discourage employers from hiring them and insurance companies from selling them coverage. AARP strongly supports requiring insurers to "take all comers" regardless of health status and prohibiting waiting periods before coverage begins. We are pleased that the debate in Congress has moved in this direction and encourage you to enact the insurance reform provisions along the lines of the President's plan. With universal coverage and a risk-adjustment mechanism that levels the playing field for health plans with higher cost enrollees, insurance companies will have no legitimate argument for denying coverage or setting waiting periods.

NEED FOR COMMUNITY RATING WITHOUT AGE ADJUSTMENTS

Perhaps the single most significant obstacle to coverage for 55–64 year olds is the high premiums they must pay. AARP strongly supports pure community rating—that is, charging all individuals or families in an area the same premium for the same benefits package regardless of age, gender, or health status. It's the way we used to do business in this country before insurance companies started "cherry picking" the healthiest groups and avoiding the less healthy groups. Many who argue against community rating charge that it rewards those who behave irresponsibly—e.g., smoking, drinking heavily, overeating, engaging in unprotected sex—or otherwise add costs to the health care system. Yet, the way to attack these problems is directly through programs addressing alcoholism, tobacco use, poor diet, and lack of education—not after the fact through insurance rating.

Moreover, the aging process should not be looked upon as a "problem behavior," even though it tends to increase health care costs. We strongly encourage Congress to reject proposals that allow insurance companies to discriminate against the pre-Medicare population by varying premiums based on age. Charging older persons higher premiums because of their age is similar to charging younger women higher premiums because they might have babies. There's no place in a reformed health care system for either of these discriminatory practices.

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[10] U.S. Census, CPS, March 1993.
[11] National Medical Expenditure Survey, 1987.
[12] Lewin-VHI estimates for the Commonwealth Fund, using 1987 NMES.

Some have suggested that insurers should be allowed to age-rate premiums as a way to make higher-income groups pay their share. AARP has long been an advocate of progressive financing in the health care system. But using age as a proxy for income is misguided and is not supported by the facts. Allowing insurers to age rate would make non-working 55–64 year-olds with low to moderate incomes pay substantially more for health coverage than younger individuals with higher incomes. If Congress wants financing for health care to be based in part on income, then it should do so directly for everyone. Age-rating premiums will not achieve that goal.

Finally, if Congress allowed age-rating of premiums, then federal subsidies for older non-workers would have to be set at a much higher level than for younger populations so that the value of the subsidy would be consistent across all age groups.

NEED FOR A SPONSOR AND SUBSIDIES TO HELP PAY FOR PREMIUMS

Even with community rating, very few non-working 55–64 year-olds will be able to pay the entire health premium on their own. There is general agreement in this country that health insurance is simply much too expensive for *individuals* to afford. That is why many businesses pay for coverage today and why an employer mandate is so important to universal coverage. That is also why Medicare was enacted and why it continues as a very popular program today. If we are to continue the employer-based system of health coverage, then non-working 55–64 year-olds will need the same kinds of protections that workers and Medicare beneficiaries will have under a reformed health care system.

Particular attention should be given to low and moderate income individuals in this age group. AARP strongly supports the President's proposed federal subsidies for non-workers with incomes up to 250% of the poverty level.

CONCLUSION

AAAP is pleased that the President's "early retiree" proposal would provide health security to a very large number of this vulnerable age group. It is important to keep in mind that *those who would benefit most from the proposal are those that currently have no health coverage at all.* They include widows and former homemakers without retiree health benefits; men and women who suddenly find themselves unable to work, underemployed, or forced out of a job; and families counting the weeks and months until both husband and wife obtain Medicare eligibility at age 65.

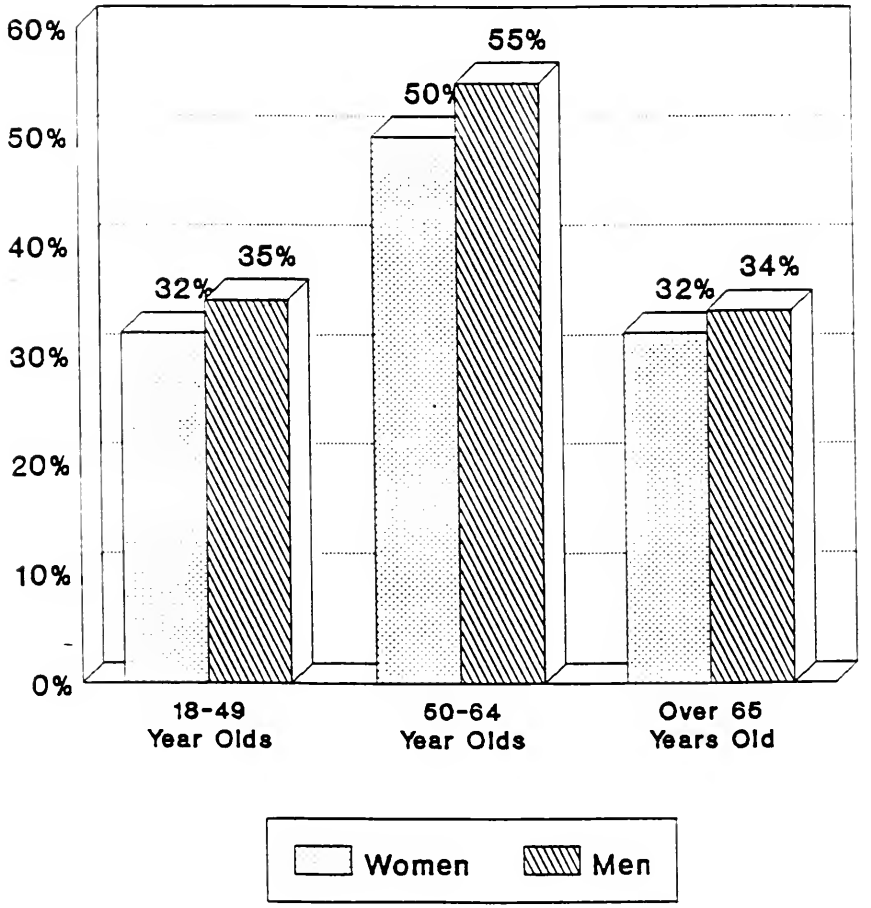
Insurance reform, community rating without age adjustments, and government subsidies are all needed to assure that vulnerable, non-working 55–64 year-olds can share in the promise of universal coverage.

As the Congress confronts the many difficult choices that must be made to reform our health care system, we urge you not to take the path of least resistance on those things that matter most to older Americans and their families. Particularly for the 50–64 year-old population, the status quo is the worst and most expensive option. And those proposals that fall to address the many health coverage problems of this population leave out a very vulnerable and vocal group. If universal coverage is the objective, and we believe it must be, Congress will need to make sure that so-called "early retirees" do not get lost in the debate.

AAAP looks forward to working with this Committee to realize the goal of universal coverage and ensure that 50–64 year-olds obtain equitable treatment in comprehensive health care reform legislation.

CHART 1

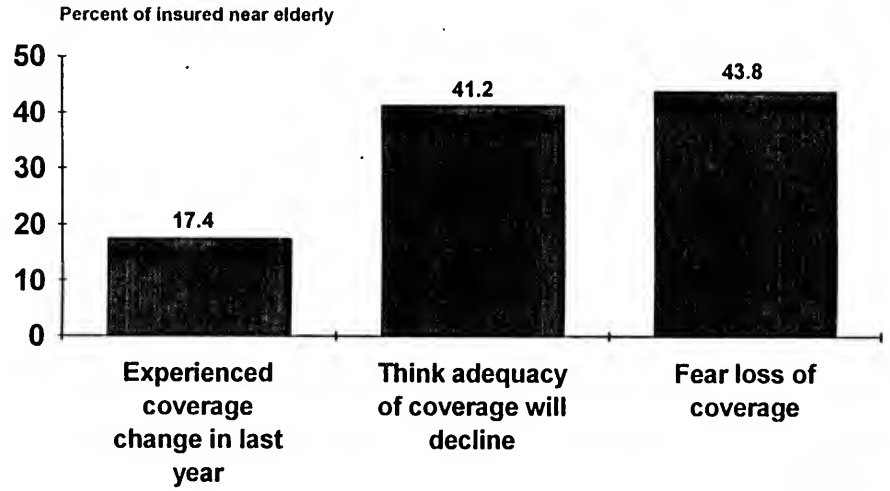
Rating of The Current U.S. Health Care System as Poor
-By Age and Gender-



Poor: Rating of 3, 2 or 1 on 10 point scale

CHART 2

Concerns of Insured 50-64 year-olds Regarding Future Health Coverage



SOURCE: Nov. 1992 AARP Survey by S. Sofaer.

CHART 1

Half of 55-64 Year Olds Either Do Not Work or Work Part-Time

Total 55-64 Year Olds: 21.2 million

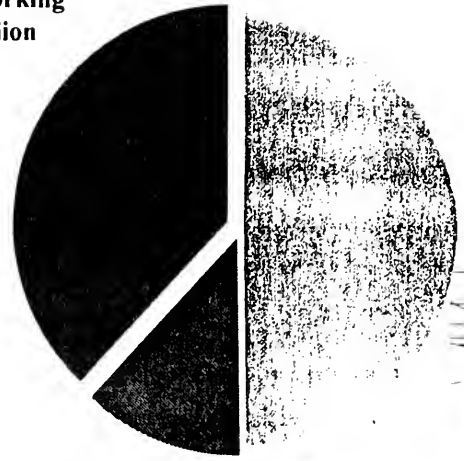
Retired

Not Working
8 million

Ill, Disabled

Other

Keeping House



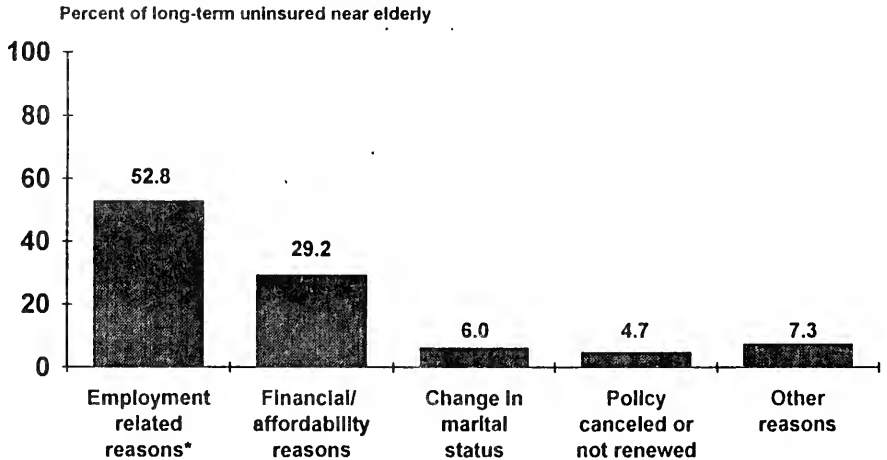
Working Full-Time
10.6 million

Working Part-Time
2.6 million

Source: U.S. Census, CPS, March 1993

CHART 4

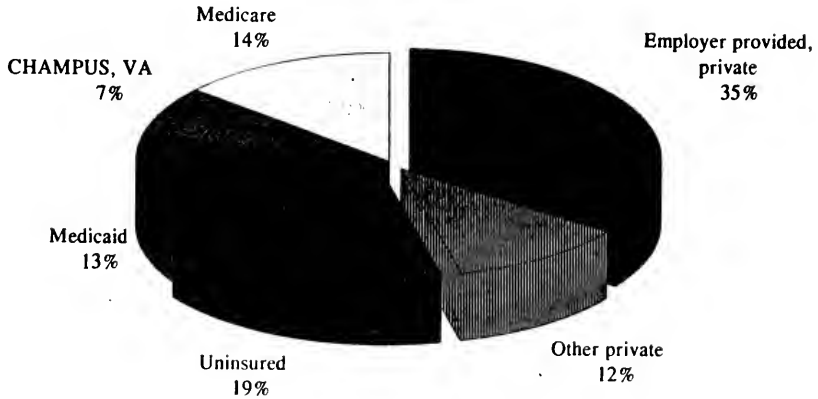
Sixty percent of uninsured 50-64 year-olds are without coverage for more than 5 years. Reasons for losing coverage:



SOURCE: Nov. 1992 AARP Survey by S. Sofaer.
*Reasons include change in work status, retirement, and elimination of coverage-offer by employer.

Only 35 Percent of Non-Working 55-64 Year Olds Have Health Coverage Through Their Or Their Spouse's Current or Former Employer

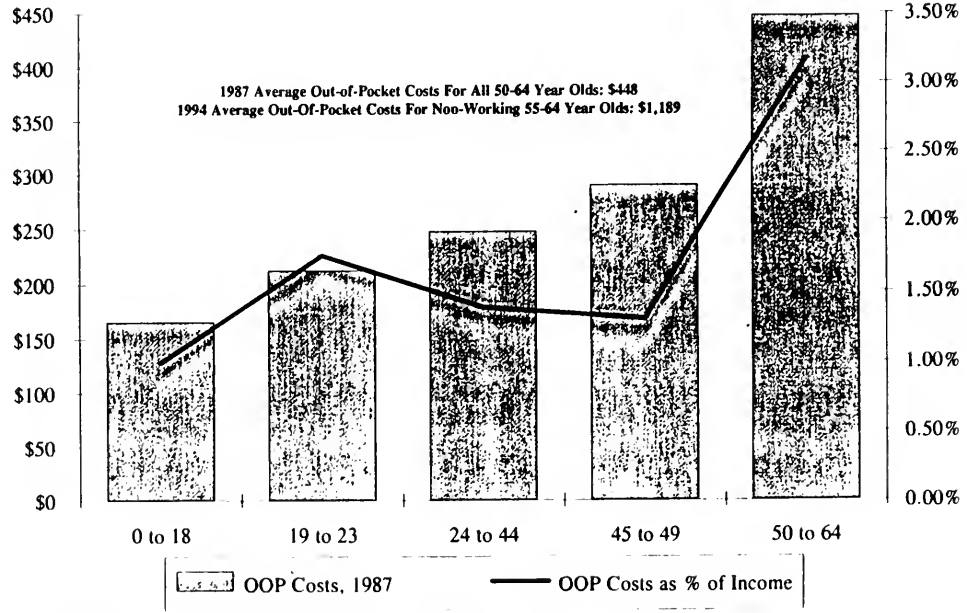
Source of Health Coverage for Non-Working 55-64 Year Olds



Source: U.S. Census, CPS, March 1993.

CHART 6

55-64 Year Olds Pay Higher Out-Of-Pocket Costs For Health Care Per Person Than Younger Populations



Source: 1987 National Medical Expenditure Survey and Lewin-VHI estimates for the Commonwealth Fund.

PREPARED STATEMENT OF WILLIAM S. CUSTER

Mr. Chairman, I am pleased to appear before you this morning to discuss the health and economic characteristics of the near elderly (those aged 55 to 64). I am Bill Custer, director of research for the Employee Benefit Research Institute (EBRI). EBRI, a nonprofit, nonpartisan public policy research organization, strives to contribute to the formulation of effective and responsible health, welfare, and retirement policies. Consistent with our charter, we do not lobby or advocate positions.

Many people find the period between age 55 and 64 to be one of transition. Marriages may end through divorce or death, health problems may arise that challenge a person's ability or desire to remain in the work force, or retirement programs may offer inducements to retire before eligibility for public programs such as Social Security and Medicare. These events may both be a result of, and result in, changes in an individual's health and health insurance coverage. They may also increase the portion of income that is devoted to health expenditures.

In 1992, the near elderly comprised 8 percent (21.2 million) of the total U.S. population (table 1). By 2020, this cohort is projected to rise to almost 14 percent of the total population.[1] Given this projected growth, it is important to consider this cohort's distinctive characteristics and sources of health insurance coverage when assessing the impact of proposed health care reforms.

HEALTH STATUS

The degree to which labor force participation is determined by choice or is forced by deteriorating health is still controversial. Some researchers discount the possibility that changes in health status have increased the rate of withdrawal from the labor force by the near elderly, attributing the increased rate of early retirement to greater preferences for leisure and the increasing availability of Social Security and other pension income.

Others argue that deteriorating health among this population has had a small but significant effect on the lower labor force participation rates. Although mortality rates at each age have improved with medical advances, particularly in recent decades, researchers disagree about how this improvement will affect future demand for medical care and individuals' ability to participate in the work force. One hypothesis posits that, while advances in medical science decrease mortality rates, they may not reduce population morbidity. Although more people might be rescued from what would previously have been a fatal bout of illness, more of the population could be left disabled. Some of these individuals who have been rescued may be responsible for growing numbers of the near elderly who are not participating in the labor force because they are disabled. The major empirical difficulty in confronting the deteriorating health hypothesis is the absence of time series data on objectively measured health conditions among older individuals. All of the measures available to the authors are socially conditioned, and the most abundant and accessible measures are self-reported.

Age itself is a good indicator of the risk of needing health care services. EBRI analysis of the National Medical Expenditure Survey indicates that individuals between the ages of 55 and 64 on average use 37 percent more health care services than those between 45 and 54 and over twice the health care services of individuals between 35 to 44.

Employment is another good indicator of the risk of needing health care services. For the near elderly, EBRI tabulations show that those who are employed have total health expenditures very near the level of younger individuals, but the non-working individuals aged 55 to 64 have health expenditures 65 percent higher than the working near elderly, and those individuals who are disabled have expenditures that are over 2.5 times those of workers.

Although the literature on the health and economic status of the near elderly is ambivalent for the group as a whole, it is clear that for many individuals aged 55 to 64 health is a major determinant of labor force participation and economic status. The sources of income may differ for the near elderly in comparison with younger cohorts, and the total income may be less. Moreover, there appear to be gender differences in both labor force participation and income. These factors may also be important in determining the presence and source of health insurance coverage at a time of life in which the need for health care may be increased.

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[1] See U.S. Department of Commerce, Bureau of the Census, *Projections of the Population of the United States, by Age, Sex, and Race: 1988 to 2080,* Current Population Reports, Series P–25, no. 1018 (Washington, DC: U.S. Government Printing Office, 1989).

THE DEMOGRAPHICS OF 55 TO 64 YEAR OLDS

The most obvious difference between 55 to 64 year olds and other age groups is in labor force participation. As table 1 indicates, almost 38 percent of the near elderly did not work at all in 1992. That compares with less than 20 percent of those aged 46 to 55 who reported that they did not work in 1992. Nine percent, or just under 2 million individuals between the ages of 55 and 64, did not work because they were either ill or disabled, 14.5 percent were retired, and 12.2 percent were taking care of their home or family. Approximately 0.01 percent never worked.

The largest difference between the near elderly and younger cohorts in labor force participation is in the number of retirees among individuals aged 55 to 64. Of those near elderly individuals who did not work at all in 1992 almost 39 percent described themselves as retired. Only 1 percent of the 46–55 year olds described themselves as retired.

Differences in labor force participation manifest themselves in differences in family income as can be seen in table 2. The median family income for working near elderly individuals is over $40,000, while the median family income for nonworking near elderly is between $20,000 and $30,000.

SOURCES OF HEALTH INSURANCE COVERAGE

Although the near elderly have lower labor force participation rates than younger age groups, the majority of those aged 55 to 64 get their health insurance coverage from an employment-based plan. Table 3 shows that 64.1 percent of the near elderly have employment-based health insurance coverage. This compares with 70.6 percent for individuals aged 45 to 54 and 66.6 percent for individuals aged 25 to 44. The near elderly are more likely than other age groups to have individually purchased private insurance plans. Almost 13 percent have a health insurance policy purchased individually, compared with 8.8 percent for individuals aged 45 to 54, and 7.1 percent in the 25 to 44 age group. The near elderly's high rate of individual coverage is a result of their weak attachment to the labor force and their increased likelihood of being disabled. They are less likely to have employment-based health coverage, yet they are more likely to need some form of health insurance than other age cohorts.[2]

With the exception of the elderly, the near elderly are the most likely age group to have publicly provided health insurance coverage. Over 17 percent had some form of public coverage, compared with 10.0 percent for the population aged 45 to 54 and 9.8 percent for the population aged 25 to 44. The major source of public insurance for the near elderly is Medicare. Individuals between the ages of 55 and 64 are more likely to have Medicare coverage because they are more likely to be disabled and qualify for the Social Security Disability Insurance program (DI). Because of their higher disability rates, the near elderly are less likely to participate in the labor force than other non-elderly age groups.

The near elderly were less likely to be uninsured in 1992 than other non-elderly age groups. Less than 13 percent of the population aged 55 to 64 were uninsured, compared with 14 percent for the 45 to 54 age group and 18.5 percent for the 25 to 44 age group. The higher rates of insurance coverage result from greater numbers of the near elderly purchasing individual coverage and greater eligibility for Medicare due to disability.

Women in this cohort are also much more likely than men to have purchased individual coverage; coverage which is much more expensive than group coverage through an employer. For example, 60.6 percent of women aged 55–64 had employment-based coverage and 15.5 percent had other private individual coverage in 1992. This compared with 68.0 percent and 10.2 percent of men, respectively (table 4).

Work status, marital status, and family income are among the characteristics associated with sources of health insurance coverage for the near elderly. For example, 71.8 percent of the near elderly who were married reported having employment-based coverage in 1992, while only 44.2 percent of the near elderly unmarried reported having such coverage. In addition, 42.8 percent of the near elderly with family income below $30,000 reported having employment-based coverage, whereas the percentage was substantially higher—80.7 percent—for those with family income of $30,000 or more (table 3).

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[2] In order to qualify for disability benefits, an individual's disability should be expected to last at least 12 months. In addition, there is a mandatory 5-month waiting period before disability benefits begin; therefore, disabled individuals are more likely to need some form of individual coverage in the interim.

Individuals between the ages of 55 and 64 who were working were more likely than non-working individuals to have employment-based insurance, but many nonworking individuals also had employment-based coverage. For example, EBRI tabulations indicate that 40.3 percent of the early retirees had direct employment-based health insurance.[3] These benefits can come in the form of employer-sponsored retiree health insurance or continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).[4] Interestingly, 11.5 percent of individuals who were looking for work were covered by an employment-based plan. These individuals are most likely using COBRA coverage as a bridge during job turnover.

The number of adults aged 18–64 who lacked health insurance coverage rose from 24.1 million (16.2 percent) in 1988 to 28.7 million (18.6 percent) in 1992. In 1992, among those aged 18 and over, individuals aged 18–24 were most likely to be uninsured (29.3 percent). Least likely to be uninsured were individuals aged 65 and over (1.2 percent). Among the near elderly, 12.9 percent lacked coverage in 1992 (table 3).

Among the near elderly reporting family income below $30,000, 21.7 percent had no health insurance coverage in 1992, compared with only 5.9 percent of those reporting family income of $30,000 or more. An even higher percentage of those aged 18◌44 and 45–54 with family income below $30,000 (35.0 percent and 31.5 percent, respectively) reported lack of coverage, compared with 10.8 percent and 6.3 percent, respectively, of those with family income of $30,000 or more (table 4).

Although individuals between the ages of 55 and 64 are more likely to be covered by some form of health insurance, this is the only age cohort in which women are more likely than men to be uninsured (table 4). Women in this age cohort are less likely than men to have an attachment to the work force, and are thus less likely to have access to group health insurance coverage. Women do purchase more individual coverage than men, but that is much more expensive than group coverage, and the ability of nonworkers to purchase such coverage is dependent upon income.

BARRIERS TO HEALTH INSURANCE COVERAGE

The near elderly do differ from younger cohorts in the source of their health insurance coverage. Lower work force participation means that the near elderly have slightly lower rates of employment-based health insurance. They are less likely to have private health insurance, and are more likely to turn to public sources for health coverage.

Nonworkers are particularly reliant on public sources or on individually purchased health insurance. The nonworking near elderly are also more likely to be uninsured than workers. Only a third of those not working because they were disabled were covered under the Medicare program; another 20 percent receive coverage through the Medicaid program.

As the near elderly become less connected to the workplace, either through their own separation or that of a spouse, the source of health insurance, and the financial consequences of purchasing health insurance coverage change. Individual health policies are available to the near elderly, but indemnity plans are expensive and prepaid plans may be unacceptable, or unavailable. Individual policies under traditional health plans may cost between $3,600 to $6,000 annually, while family policies may cost as much as $12,000, annually. These policies may not be available without medical underwriting (i.e., the applicant undergoes a physical before the policy is written).

As many as 40 percent of those near elderly who are retired may have coverage from a former employer, or continuation coverage under COBRA. Coverage under COBRA requires that the individual pay up to 102 percent of the premium for continuation of coverage under a former employer's health plan, but because the individual is allowed to continue to purchase coverage through a large group, there is

[3] Direct employment-based coverage is coverage in one's own name. Indirect employment-based coverage is coverage provided through someone else's employer.

[4] The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires employers with health insurance plans to offer continued access to group health insurance to qualified beneficiaries. COBRA requires continued access for 18 months for employees (29 months for the disabled) and 36 months for qualifying spouses and dependent children. Some states also have continuation of coverage laws. See Employee Benefit Research Institute, *Fundamentals of Employee Benefit Programs*, 4th edition (Washington, DC, 1990), for more information about the federal law, and J. Gruber, and B.C. Madrian, "Health Insurance Availability and the Retirement Decision," NBER Working Paper No. 4469 (Cambridge, MA: National Bureau of Economic Research, 1993), for a listing of state laws.

likely to be considerable savings over the cost of purchasing coverage as an individual.

EMPLOYER PROVISION OF RETIREE HEALTH BENEFITS

Generally, only large employers have historically offered health insurance to retirees. The growth in the costs of health benefits coupled with changes in the accounting of liabilities for retiree health benefits has led many employers who have offered health benefits to reconsider the nature and extent of that promise. A recent survey of employers by A. Foster Higgins[5] found that 42 percent of the large employers surveyed (those with more than 500 employees) offered health insurance to retirees; 41 percent of those offering coverage provide no contribution toward that coverage. Larger employers (those with more than 5,000 employees) are much more likely to offer retirees coverage and to contribute to that coverage. Over 70 percent of employers surveyed with more than 5,000 employees offered retirees health benefits.

The Foster Higgins survey found that over one-third of those employers who offer retiree coverage had made changes in that coverage, with the most common change resulting in increased out-of-pocket costs for retirees, either for increased contributions to the premium, or increased deductibles and copayments. Another 35 percent of employers surveyed stated that they planned to make changes in their retiree health benefits by 1995.

HEALTH BENEFITS AND RETIREMENT

Providing health care benefits for early retirees is an important policy issue because individuals within this age group are already least likely to be working and most likely to face uncertain health care expenditures when compared with other age groups within the nonelderly population.[6] The near elderly population is a relatively high-risk population that generally does not qualify for Medicare benefits; furthermore, privately purchased health insurance can be a costly commodity for this group. The availability of low cost post-retirement health insurance is an incentive for the near elderly to retire early. The Foster Higgins survey found that among large employers who offer retiree health benefits to retirees under the age of 65, the median age of retirement was 62; two-thirds of those retiring were under 65. For those large employers not offering retiree coverage, the median age of retirement was 64, while the median age of retirement for those small employers not offering retiree health benefits was 65, with only one-third retiring before age 65.

CONCLUSION

While it is clear that the cost of health care services is an important component of consumption of individuals aged 55 to 64, it is particularly important for nonworkers in this age group. Individuals unattached to the work force may be particularly vulnerable in that they are either in poorer health or face higher costs in purchasing health insurance benefits, or both.

It is difficult to generalize about this age cohort: it contains many healthy individuals interested in working for many years to come, as well as individuals seeking sufficient income to retire. It includes individuals who are forced to withdraw from the labor force due to poor health, and individuals who lack health insurance coverage because their connection to employment-based coverage is lost due to death, divorce, or retirement of a spouse.

The ages between 55 and 64 is the period in which many people transition out of their career jobs, and often out of the labor force. This transition maybe due to poor health, inability to meet the physical demands of the job, or preference for retirement. It is clear from looking at both individual and employer behavior that the transition is difficult without access to affordable health insurance. The availability of retiree health benefits is an important component of early retirement programs of employers attempting to downsize, for example. Any program to extend coverage to this group will affect the transition from worker to retiree.

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[5] A. Foster Higgins, *National Survey of Employer-Sponsored Health Plans / 1993.*

[6] Between 1955 and 1985 the labor force participation rate of males aged 55 to 64 declined by over 19 percent, compared with a 4.5 percent decrease for males aged 45 to 54. Some researchers attribute this decline to an increase in the ease of qualifying for disability benefits. See D.O. Parsons, "The Decline in Male Labor Force Participation," *Journal of Political Economy* (February 1980): 117–134, and J. Bound, "The Health and Earnings of Rejected Disability Insurance Applicants," *American Economic Review* (June 1989): 482–503, for alternative theories on the decline in the male labor force participation rate.

Table 1
Major Activity of Individuals Aged 55-64, 1992

Activity	Percent	Millions
Total	100.0%	21.2
Worked	62.2%	13.2
Did Not Work	37.8	8.0
Ill or Disabled	9.1	1.9
Retired	14.5	3.1
Taking Care of Home or Family	12.2	2.6
Going to School	0.02	0.04
Could Not Find Work	1.5	0.3
Other	0.5	0.1
Never Worked	0.01	0.004

Source: Employee Benefit Research Institute tabulations of the March 1993 supplement to the Current Population Survey

Table 2
Distribution of the Near Elderly by Work Status and Family Income

Family Income	Workers		Non-workers	
under $5 thou	167,125	1%	656,854	8%
$5 to $10 thou	431,967	3%	1,162,588	14%
$10 to $20 thou	1,533,447	12%	1,940,044	24%
$20 to $30 thou	1,988,572	15%	1,356,311	17%
$30 to $40 thou	1,953,121	15%	965,935	12%
$40 to $50 thou	1,623,021	12%	687,550	8%
$50 to $60 thou	1,404,694	11%	447,122	5%
$60 to $70 thou	1,009,627	8%	269,901	3%
more than $70	2,911,776	22%	683,483	8%
Total	13,023,350	100%	8,169,788	100%

Source: EBRI tabulations of the March, 1993 supplement to the Current Population Survey

Table 3
Sources of Health Insurance Coverage by Age, 1992
Employee Benefit Research Institute Analysis of the March 1993 CPS

Source of Health Insurance	Total Aged 18 and Over	18-24	25-44	45-54	55-64	65+
			(millions)			
Total	185.5	24.0	81.1	28.4	21.2	30.9
Total Private	134.0	14.4	59.8	22.6	16.4	20.9
employer	108.2	10.4	54.0	20.1	13.6	10.1
direct	76.1	4.9	39.8	14.4	9.6	7.3
indirect	32.1	5.5	14.1	5.6	4.0	2.8
other private	25.8	4.0	5.8	2.5	2.7	10.8
Public	47.5	3.3	7.9	2.8	3.7	29.8
Medicare	33.6	0.2	1.3	0.7	1.7	29.7
Medicaid	14.1	2.7	5.9	1.3	1.2	2.9
CHAMPUS[a]	5.5	0.6	1.4	1.1	1.3	1.2
Uninsured	29.1	7.0	15.0	4.0	2.7	0.4
			(percentage within age categories)			
Total	100.0%	12.9%	43.7%	15.3%	11.4%	16.6%
Total Private	100.0	10.8	44.6	16.8	12.2	15.6
employer	100.0	9.7	49.9	18.5	12.6	9.3
direct	100.0	6.5	52.4	19.0	12.6	9.6
indirect	100.0	17.2	44.1	17.5	12.5	8.7
other Private	100.0	15.4	22.4	9.7	10.6	41.9
Public	100.0	6.9	16.7	6.0	7.7	62.7
Medicare	100.0	0.5	3.8	2.2	5.0	88.5
Medicaid	100.0	19.2	42.2	9.3	8.6	20.7
CHAMPUS[a]	100.0	10.5	25.7	19.4	23.0	21.5
Uninsured	100.0	24.2	51.5	13.7	9.4	1.2
			(percentage within coverage categories)			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total Private	72.2	60.1	73.8	79.4	77.1	67.7
employer	58.3	43.6	66.6	70.6	64.1	32.6
direct	41.0	20.6	49.2	50.8	45.2	23.6
indirect	17.3	23.0	17.5	19.8	19.0	9.0
other private	13.9	16.6	7.1	8.8	12.9	35.0
Public	25.6	13.7	9.8	10.0	17.3	96.6
Medicare	18.1	0.7	1.6	2.6	8.0	96.2
Medicaid	7.6	11.3	7.3	4.6	5.7	9.4
CHAMPUS[a]	3.0	2.4	1.8	3.8	6.0	3.9
Uninsured	15.7	29.3	18.5	14.0	12.9	1.2

Note: Details may not add to totals because individuals may receive coverage from more than one source.

[a]Includes only the retired military and members of their families provided coverage through the Civilian Health and Medical Program for the Uniformed Service and the Civilian Health and Medical Program for the Department of Veterans' Affairs. Excludes active duty military personnel and members of their families.

Table 4
Sources of Health Insurance Coverage, by Age, Marital Status, Family Income, and Work Status, 1992
Employee Benefit Research Institute Analysis of the March 1993 CPS

	Employer Coverage				Individual Coverage				Total Public				Uninsured			
	18-44	45-54	55-64	65 and Over	18-44	45-54	55-64	65 and Over	18-44	45-54	55-64	65 and Over	18-44	45-54	55-64	65 and Over
	(percentage)															
Total	61.4%	70.6%	64.1%	32.6%	9.3%	8 8%	12.9%	35.0%	10.7%	10.0%	17.3%	96.6%	21.0%	14.0%	12.9%	1.2%
Men	60.2	71.1	68.0	39.6	9.5	8 3	10.2	29.7	7.4	9.9	17.2	95.8	24.7	14.3	12.2	1.2
Women	62.4	70.1	60.6	27.7	9.1	9.3	15.5	38.8	13.9	10.0	17.4	97.1	17.3	13 8	13.5	1.1
Marital Status																
Married	74.8	76.5	71.8	42.9	6.4	8.3	11.6	32.3	7.1	8 1	14.3	96.5	14 1	11.0	10.2	0.9
Men	74.8	76.7	74.6	43.7	6 1	7.6	9.3	30.8	6.1	8.3	14.9	96.0	15.1	11.3	9.2	1.0
Women	74.8	76.2	68.7	41.8	6.6	9.0	14.1	34.2	8.1	7.9	13.5	97.1	13.2	10.7	11.4	0 8
Unmarried	46.6	53.9	44.2	19.8	12.5	10.3	16.4	38.5	14.5	15.3	25.2	96.6	28.5	22.7	19.6	1.4
Men	45.9	51 3	44 1	26.9	12.9	10.6	13.2	26.3	8.6	15.9	25.6	95.3	34 2	25 0	22.9	1.9
Women	47.4	55.7	44.3	17.8	12.1	10.0	18.4	42.1	21.0	14.9	25.0	97 0	22.3	21.1	17.7	1.3
Family Income																
Under $30,000	37.5	40.1	42.8	24.6	9.8	11 0	16 5	38.0	20.5	20 4	26 3	97.9	35.0	31 5	21.7	1.1
Men	37.0	37.1	43.6	29.9	9.8	10.2	13 2	32.4	13.4	21.6	27.6	97.7	41 9	34 8	23 3	1.2
Women	38 0	42 4	42 2	21.3	9 7	11.7	18 9	41.4	26.7	19.5	25 3	98.0	28.9	29.0	20.6	1.1
$30,000 or more	78.6	84.1	80.7	51.3	9 0	7.8	10.2	28.2	3.6	5.3	10 3	93.4	10.8	6.3	5.9	1.2
Men	75.5	84.1	82.7	56.9	9 3	7.5	8 4	25.0	3.4	5 5	10.9	92.4	13.4	6.4	5 5	1.3
Women	81.8	84.0	78.4	45.9	8.6	8 1	12.3	31.5	3.8	5.2	9.6	94.4	8.1	6.2	6.5	1.1

Source: Employee Benefit Research Institute tabulations of the March 1993 Supplement to the Current Population Survey

Table 5

Primary Sources of Health Insurance Coverage for the Near Elderly by Work Status[a]

	Employer Direct	Employer Spouse	Other Private	Medicare	Champus	Medicaid	Uninsured
Worked	7,936,482	1,919,903	1,465,858	83,746	233,943	54,119	1,514,625
Non-Working	1,656,044	2,108,380	1,058,949	1,103,117	245,370	644,055	1,214,716
	Percentage within Coverage category						
Worked	83%	48%	58%	7%	49%	8%	55%
Non-Working	17%	52%	42%	93%	51%	92%	45%
	Percentage within Work Status category						
Worked	60%	15%	11%	1%	2%	0%	11%
Non-Working	21%	26%	13%	14%	3%	8%	15%

Source: EBRI tabulations of the March, 1993 supplement to the Current Population Survey

[a]Numbers do not match table 2 because individuals are assigned to primary source of coverage only in this table; in table 2 individuals may have multiple sources of coverage.

PREPARED STATEMENT OF GERALD W. MCENTREE

Mr. Chairman and members of the Subcommittee, I am Gerald W. McEntee, President of the American Federation of State, County and Municipal Employees (AFSCME). I would like to thank you for the opportunity to testify about the impact of health care reform on workers and retirees.

As the leader of the nation's largest union of public employees and health care workers with 1.3 million active members and 160,000 retirees, I want you to know that there is no more crucial issue before you than the health security of all Americans. I am also here today as a member of the Pre-Medicare Health Security Coalition. This is a broad-based coalition of unions, corporations, state and local government organizations, aging groups and other public interest organizations. A list of those participating in the Coalition is attached to my testimony.

The focus of today's hearing, the health care coverage of Americans aged 55–64 who are unemployed, displaced, under-employed or retired, but who are not yet eligible for Medicare, deserves your special attention. AFSCME and the other member organizations of the Pre-Medicare Coalition are deeply concerned that the unique problems which those aged 55–64 confront in securing health care coverage could easily be neglected and that this group could continue to fall through the cracks of the health care system.

In our employer-based health care system, which is all but certain to remain as the basis for any health care reform passed in this Congress, those who are not working are at a real disadvantage. Currently, one-fourth of the over 21 million Americans aged 55–64 are not working and frequently have inadequate health care coverage. This group will continue to face discrimination under a reformed health care system unless adequate provisions are made to insure that their access to health insurance is guaranteed and affordable. To advance the goal of universal coverage, health care reform must assure affordable and comprehensive health benefits for nonworking Americans 55–64.

Workers 55–64 have become increasingly vulnerable to being laid off or displaced and losing health benefits. State and local governments, often confronted with annual budget shortfalls, usually solve their fiscal problems with forced early retirements and layoffs as well as wholesale contracting out of public services. Many state and local governments proceed on the assumption that the most humane way to accomplish their downsizing is with a program that encourages early retirement. This can avoid the layoff of younger employees who have a longer work future ahead of them. Forcing the retirement of older workers also saves governments more money as older workers are generally higher paid employees.

Just recently when New York City was faced with a $2.3 billion gap in the budget, Mayor Giuliani and the municipal unions, the largest of which is AFSCME District Council #37, agreed on a package of severance offers that was designed to

achieve a reduction in the number of city workers and avert layoffs. Six thousand city workers volunteered to leave the city payroll of whom 4,285 were represented by AFSCME. One thousand two hundred and four of the AFSCME workers who accepted the severance offer were aged 55–64.

These actions in the public sector have been mirrored in the private sector as U.S. companies downsize and pursue a low wage strategy which increasingly utilizes part-time and contingent workers at home and relocates jobs abroad. Earlier this week, the outplacement firm Challenger, Gray & Christmas reported that work force reductions through May of this year were running 18 percent ahead of the first five months of 1993.

Older workers in both the public and private sectors, with higher average wages and rapidly escalating health costs, who lose their jobs during state and local government budget crises, corporate downsizing and restructuring, and defense conversion, often have great difficulty becoming reemployed. Of those who do find work, most receive fewer benefits and replace less than 80 percent of their former wages.

Workers over age 55 who become unemployed subsequently leave the work force entirely at much higher percentages than younger workers. According to a Congressional Budget Office analysis of data through 1990, over one-half of displaced workers 60 and older and over one-fourth of displaced workers between the ages of 55 and 59, left the work force. Such forced retirements artificially held down the unemployment rates for these categories, which otherwise would have been much higher. We know that hiring discrimination against older persons is fueled to some degree by their high health care costs. The sad thing is the fact that older displaced workers become retirees not by their own choosing, but because of forced layoffs and the lack of labor force mobility for individuals in this age range.

Persons in jobs requiring physical labor—jobs that are filled disproportionately by minority workers—are especially vulnerable to job loss as they age. Because minorities die at younger ages statistically, this population faces a kind of double jeopardy—crucial years before the age of 65 with no coverage or inadequate coverage, and then a lower life expectancy which too often means they do not receive the health coverage from Medicare that they earned in their working years. Laid-off workers often have only COBEA health benefits for up to 18 months—benefits which must be paid entirely by the displaced worker. Yet three-fourths of pre-Medicare retirees have family incomes of less than $25,000.

Nonwhite retirees are only half as likely as whites to have health benefits from former employers. And women are only half as likely as men to have such benefits.

Older workers are also highly susceptible to "job-lock." Fear of reduced health care coverage and poor job prospects stop older workers from changing jobs or trying something new. This impairs upward labor mobility for younger workers and may lower overall productivity.

While 40 percent of former employees have health insurance based on their past employment for many this merely means that they were enrolled in a former employer's health plan with only modest financial assistance at best. The majority are faced with the choice of paying five to ten times more for health insurance than those with employer-paid coverage, often for inferior coverage, or going uninsured, as an estimated 2.7 million people in this age category did in 1992.

While continuation of access to health insurance coverage after either early or normal retirement is a common feature of public employer plans it is far from universal, nor does it guarantee affordability. Fifteen states make no contribution to the retiree's health coverage at all. Just looking at the indemnity plan costs for non-Medicare eligible retirees from state government in states represented by members of the Subcommittee, in Michigan early retirees pay 5.2 percent; in New York, 11 percent; in Minnesota, 25.2 percent; in West Virginia, 74.1 percent; in Missouri, 94 percent; and in New Jersey, 100 percent.

The latest data available indicates that there are over 4 million retirees from state and local governments in this country receiving pension benefits. The average annual pension benefit is $9,276, half the median for all nonworking couples aged 55–64. Even when the past employer is picking up a share of the health premium, the average cost to the retiree for health insurance coverage has become unaffordable. The average health premium cost to a retiree from state government for single coverage is $923 per year or 10 percent of the average public employee's pension. The cost of the premium to the retiree rises to $2,574 annually or 28 percent of the average pension for coverage which also covers a dependent.

The General Accounting Office estimates that 96 percent of America's employers offer no health benefits to retirees. A national survey shows that companies are steadily reducing or eliminating such benefits. For those companies that still offer coverage, generally large employers, the recent change in the Federal Accounting Standards Board (FASB) rule, Standard 106 which requires reporting on financial

statements the liability associated with employer coverage of retiree health benefits, has increased the pressure on companies to cut back such benefits, or even terminate them—particularly for newer workers.

Public employer and employees are very concerned about the prospect of FASB Standard 106 being applied to the public sector at some future date. If this occurred, it would force public-sector employers to pre-fund early retiree health care. This result could be huge budgetary outlays, weakened bond ratings, and further aggravated financial problems for state and local governments. Or, they could mean cutbacks or elimination of early retiree health coverage.

Just as fewer companies in the private sector offer retiree health coverage, public employers are responding to the crisis in our country's health insurance system and their rising retiree health costs by shifting more of the burden of health costs to the retiree—higher premium contributions, increased cost sharing and tightening eligibility requirements, such as age and length of service. One recent study showed that 10 percent of state governments had tightened eligibility requirements since 1990 and another 4 percent planned to do so.

An important principle that should be incorporated into health care reform is the principle of horizontal equity—the comparable treatment of persons of the same age and income levels. Our nation's health care system fails this test today, and could fail it under health care reform.

Persons aged 55–64 are particularly vulnerable to unequal treatment. Persons who are working and receive health coverage from their employers pay a relatively small amount of their income for health insurance coverage, while most of those who are not working pay several times as much in dollar terms and as a proportion of income.

The median income of a couple with at least one person aged 55–64 who is working was $33,304 in 1991. Under the bill approved by the House Ways and Means Subcommittee on Health, this family would expect to pay 2.4 percent of their income or about $800 per year which represents 20 percent of the full $4,000 premium with the employer paying the remaining 80 percent.

Nonworking couples 55–64 have median incomes of only $20,000 and three-quarters have family incomes below $25,000. Under the Ways and Means Subcommittee plan a nonworking couple with $20,000 in income would be required to pay the entire $4,000 premium, or 20 percent of their income, in addition to out-of-pocket costs which can easily reach as high as $2,000-$3,000 per year. This glaring inequity can only be corrected with subsidies for older, nonworking persons. Once again, I want to stress that access to health insurance is meaningless if it is not affordable.

Unlike the Ways and Means Subcommittee plan which makes no provision for the special needs of the group 55–64, the President's proposal, as originally introduced, goes a long way in equalizing the costs of working and nonworking persons 55–64. The President's health reform plan address the problems faced by the pre-Medicare population by including a provision under which the government pays the "employer share" of health coverage for nonworking persons aged 55–64 in order to protect vulnerable individuals. This provision is key to meeting the goal of universal health coverage. The Clinton early retiree provision was approved by Senator Kennedy's Labor and Human Resources Committee on June 9th and is also included in the bill approved by the House Education and Labor Subcommittee on Labor-Management Relations chaired by Congressman Pat Williams.

With the same median income of $20,000, the nonworking couple under the President's plan would pay 20 percent of the cost of the $800 premium which would be 3.8 percent of their income, instead of $4,000 under the Ways and Means Subcommittee plan which is equal to 20 percent of their total yearly income.

It is doubtful that New York City would have succeeded in persuading 1,204 AFSCME workers aged 55–64 to accept the recent early retiree offer, except for the fact that New York City is exceptional in providing retirees who meet minimum age and years of service with health care coverage that is identical to what active employees receive. While this has permitted the City to ease out of its most recent fiscal jam, such generous coverage is unlikely to be available forever. And a New York City retiree on the average annual pension of $10,000 to $12,000 would not be able to afford the cost of the City's basic benefit package, presently $1,789 for a single person and $4,361 for the family plan. In 1992, only 12 states paid the full cost of health coverage for single retirees under age 65.

The budgetary impact of the provision in the President's bill to pay the 80 percent "employer share" of the premiums for nonworking individuals aged 55–64 is estimated by the Administration to cost $13.4 billion through the year 2000.

That cost is fully offset by $17.2 billion in new revenues and savings over the same time period:

1. For calender years 1998–2000, employers will pay 50 percent of the greater of (a) the average cost of providing health benefits to this group during the years 1991–1993, indexed for medical price increases, or (b) the money employers will save in the current year by not having to pay for health benefits for this group. This employer assessment raises $11.4 billion.

2. Retirees in this group with high incomes will have to pay a tax to recapture the subsidy they receive. This tax provision saves $0.2 billion.

3. Savings to federal employee health programs (both civilian and military) will result from shifting early retiree health costs into the new program. OMB estimates savings of up to $5.6 billion (a small portion of these savings are expected to be used to provide a supplemental wraparound plan to maintain value of current benefits).

The net result over the budget period is revenue and savings in excess of costs of $3.8 billion which is used to help pay for other provisions. (A table which specifically outlines the cost and revenues associated with the pre-Medicare provision is attached.)

Assisting the nonworking Americans aged 55–64 with health care will not just benefit individuals, but will boost U.S. competitiveness. U.S. corporations that still provide retiree health benefits are often hurt competitively. Global competitors do not pay directly for retiree health care. Domestic competitors may have a younger work force or a much lower ratio of retirees to active workers, or a policy of no retiree benefits. Retiree health costs add about $15 to a cost of a ton of steel at many U.S. steel mills and an average of $600 to the cost of every car made by America's big three auto companies. Companies providing retiree health benefits are increasingly faced with the "Hobson's choice" of reducing such benefits—increasing the problems of the pre-Medicare retirees—or becoming less competitive.

Workers who in the past may have sacrificed wage increases at the bargaining table in order to protect health care coverage after retirement have struck out twice foregone wages and now, forced early retirement with diminished benefits. Many are likely to face a third strike out—being unable to afford any health care coverage after working as a productive member of the society for decades.

Federal support for early retiree health coverage would produce large savings for state employee health benefits programs and therefore relieve the pressure on state budgets who are constantly forced to make unacceptable choices about cutting services. States as employers would save an estimated $704 million on premium spending for retirees aged 55–64 in the year 2000.

In conclusion, federal coverage of the "employer" share for the nonworking pre-Medicare population is an important aspect of providing universal coverage which is affordable to all Americans. It will assure coverage for an important demographic group which has significant problems related to affordable health care coverage, relieve the fiscal burdens of state and local governments, increase the labor mobility of millions of Americans who can be productive workers for years more and increase the competitiveness of U.S. companies.

PRE-MEDICARE HEALTH SECURITY COALITION

The Pre-Medicare Health Security Coalition was formed to assure health care security for middle-class Americans ages 55-6- and their families. The broad-based coalition of organizations represents persons who are displaced, dislocated, unable to work under-employed or retired. The coalition includes labor, business, senior citizens, consumer, education, and state and loca. government organizations.

The following is a partial list of organizations which have been participating in the Coalition:

AFL-CIO
Airline Pilots Association
ALCOA
Allied Signal
American Airlines
American Association of Retired Persons
American Automobile Manufacturers Association
American Corn Growers Association
American Federation of State, County and Municipal Employees
American Iron and Steel Institute
Armco, Inc.
Bethlehem Steel Corporation
Bituminous Coal Operators Association
Chrysler Corporation
Citizen Action
Communications Workers of America
Ford Motor Company
General Motors Corporation
Government Finance Officers Association
International Association of Fire Fighters
International Association of Machinists and Aerospace Workers
International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America
International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers
International Ladies Garment Workers Union
LTV
McDonnell Douglas Corporation
National Association of Counties
National Association of Farmer Elected Committee Men
National Association of Letter Carriers
National Consumers League
National Council of Senior Citizens
National Education Association
National Rural Letter Carriers Association
National School Boards Association
National Steel
NYNEX
Owens-Illinois
International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW)
United Mine Workers of America
United Steelworkers of America
USX

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BUDGETARY EFFECTS OF PRE-MEDICARE PROVISION UNDER CLINTON HEALTH CARE REFORM PROPOSAL
Administration estimates (in billions of dollars)

	1994	1995	1996	1997	1998	1999	2000	Totals 1994-2000
PRE-MEDICARE PAYMENTS FOR RETIREES AGE 55-64 *	0.0	0.0	0.0	0.0	3.5	4.8	5.1	13.4
OFFSETS	0.0	0.0	0.0	0.0	-2.4	-4.4	4.8	11.6
Assessment on Employers for Pre-Medicare Payments **	0.0	0.0	0.0	0.0	-2.4	-4.3	4.7	11.4
Recapture Pre-Medicare Payments From High-Income Recipients **	0.0	0.0	0.0	0.0	0.0	-0.1	0.1	0.2
TOTAL	0.0	0.0	0.0	0.0	1.1	0.4	0.3	1.8
FEDERAL SAVINGS ATTRIBUTABLE TO THIS COHORT*								
Savings from elimination of Federal Employees Health Benefit Program and changes to health care for retired Military	0.0	0.0	0.0	0.0	-1.3	2.0	2.2	5.6
TOTAL, INCLUDING FEDERAL OFFSETS	0.0	0.0	0.0	0.0	-0.2	1.8	1.9	3.8

EXPLANATION OF PROVISIONS

Pre-Medicare Payments for Retirees Age 55-64
The Federal government will pay 80 percent of the premium cost for retirees age 55-64 who are not working full time in second careers and who are vested for Social Security (40 quarters of coverage).

Assessment on Private and State and Local Employers for Pre-Medicare Payments
For calendar years 1998-2000, employers would have to pay 50 percent of the greater of
(1) the average cost of providing health benefits to retirees between age 55-64 during the years 1991-1993 indexed for medical price increases; or
(2) the employer savings in the current year for providing health coverage to retirees age 55-64.
Reporting requirements and interest and penalties for failure to make timely payment would apply in the same manner as in the case of Federal employment taxes.

Recapture Subsidies From High-Income Recipients
Effective January 1, 1998, individuals with modified Adjusted Gross Incomes of $90,000 for an individual and $115,000 for a couple would repay the retiree subsidies. The subsidy would be recaptured over the taxable income range of $15,000 above the modified AGI for individuals and $30,000 for couples.

FEDERAL SAVINGS ATTRIBUTABLE TO THIS COHORT

A portion of the Federal savings results from the low-income subsidy program in the President's plan, but most of the savings is attributable to the Pre-Medicare provision. The Administration could not provide a detailed breakdown.

DOD Military Retirees Age 55-64
DOD currently pays the cost of health care provided to its non-working retired beneficiaries. This estimate assumes that DOD will continue paying twenty percent of the cost of the care. The savings are an estimate of 80 percent of the cost of health care for non-working beneficiaries who would choose to use DOD health care under national reform. Savings of $0.8 billion to DOD for the period, fiscal years 1998-2000, are included in the Federal Savings Attributable to this Cohort.

Federal Civilian Retirees Age 55-64
The savings result from shifting the employer-share of premiums away from the Government as an employer and onto the broader national health reform program. Currently, the Federal government pays for its share of health cost for retirees through the Federal Health Benefits Program, which will be eliminated. After January 1, 1998, the Federal government would no longer make direct contributions to the Federal Employee Health Benefits Program for premiums for Federal civilian annuitants age 55-64. This population will be covered under the Pre-Medicare Provision. A portion of the savings for the period, fiscal years 1998-2000, included in the Federal Savings Attributable to this Cohort is expected to be used to provide a supplemental wrap around plan to maintain the existing level of benefits for federal annuitants.

Notes
TOTALS CALCULATED FROM ADMINISTRATION ROUNDED NUMBERS
* *Source: Office of Management and Budget, November 1993 Administration Estimates of the Health Security Act.*
** *Source: Office of Management and Budget, Budget of the United States Government, Fiscal Year 1995 (February 7, 1994), Chapter 4.*
*** *Source: Clinton Administration "Documentation of Federal Budgets Effects" for the Health Security Act of 1993 obtained by BNA (Dec. 15, 1993).*

Prepared by: CHAMBERS ASSOCIATES INCORPORATED

PREPARED STATEMENT OF SUSAN TANAKA

Thank you, Mr. Chairman, for the opportunity to appear before you today. My name is Susan Tanaka. I am the Vice President for the Committee for a Responsible Federal Budget, a non-profit, bipartisan educational organization. We are committed to the task of educating the public about budget and fiscal policy issues. We believe that informed voters will make and support more informed public policy choices.

Let me start by saying that I am not a health care expert. I am a budgeteer, but that is appropriate because the health care reform debate is largely a budget debate. It is about establishing priorities and allocating resources among competing interests. It is also about raising the resources that we need to pay for the spending we want.

The hard part of the health care debate is not deciding what benefits we want. Without budgetary constraints, we'd want it all. But we do have limited resources. So we must reconcile what we want with what we are willing and able to pay. This requires some very tough choices.

We want to increase access to health insurance (or financing) and, at the same time, control overall costs. The issues are complicated, but keeping in mind a few basic facts helps to separate the forest from the trees when trying to decide what new benefits to provide.

Fact Number 1. No matter how much money we spend, no matter what plan you enact, we cannot ensure eternal life. We cannot even buy health. Bad things will still happen to good people.

We want more health care, but we don't want to pay the bill. Greedy doctors and insurance companies are not really the cause of rapidly increasing costs. We each are the problem.

Fact Number 2. People pay for health care—not employers, not government. We pay for health care three ways: through out of pocket expenditures from our after-tax income (for costs not covered by insurance); through foregone cash compensation (when employers make contributions on our behalf for health insurance); and through taxes that support Federal, State and local programs. Health care reform may change the amount of money funneled through each of these channels, but we still will end up paying the entire bill one way or another.

We might like to, but we cannot repeal basic laws of economics. While it is more popular to talk about making employers pay for employees' coverage, the simple truth is that employees will eventually pay the bill—in foregone cash compensation, or in lower real wages. Since that is the case, hiding the cost through an employer mandate is counterproductive. It perpetuates the very myth that makes controlling health care costs so difficult to begin with—the myth that someone else will pay for the benefits we want.

Adding new Federal subsidies for early retirees would not be free either. Those who continue to work would pay the bill. Under the President's broad community rating scheme, younger workers would pay twice—once through significant cross-subsidies to older workers, particularly those between the ages of 55–64; and through additional taxes. The pre-retiree age group could receive triple subsidies: an estimated $2,000/yr from community rating, income-tested individual subsidies, and the additional Federal subsidies you are concerned with.

Fact Number 3. We do ourselves no favors by hiding the cost of health care. We need as strong a consensus around the financing of health care benefits as around benefits. If people do not acknowledge and understand the costs, they will be unable to accept the measure required to keep these benefits affordable.

Notably absent from the health care discussion—or at least not readily available to the public—are consistently priced line-item cost estimates for the specific benefits under Congressional consideration. The fact that I spent many, largely unsuccessful hours yesterday trying to understand the estimates of the cost of the early retiree benefits makes the point. How can we make intelligent choices if we do know the cost?

My auto insurance bill lays out costs very clearly—so much for this level of collision coverage; so much for towing. I can decide whether I'd rather increase my coverage or decrease my premium. And, if I drive carelessly and have an accident, the cost of that behavior is soon visible in the premiums I am required to pay. People should have available the same type of information before you make up your minds about what package of health benefits health care reform will require.

Congress and the President should tax finance those benefits and services you deem to be national priorities. While individuals may disagree about the right level of funding for these activities, all Americans should help pay the bill. Some activities, like national defense, are essential to all Americans and should be available to all without regard to individual circumstances. The country has reached a consen-

sus that other Federal activities, like Medicaid and AFDC, should be available to those who need help. Whether and where new health care benefits fit within these categories is still under active public debate.

Consensus about the financing means being open about where the money comes from. Call them whatever you like, *mandates are taxes.* They would be compulsory. The resources would be used to finance Federally-designated purposes. If avoiding the word "Tax" is necessary for political expediency, then maybe the public doesn't agree with the policy. Being honest about the cost of public choices is important. Unless you are, not only will voters be unable to make informed decisions and hold our government accountable, but they will be unable to sustain the consequences of the decision you make.

Fact Number 4. You cannot spend the same money twice. We cannot solve the budget deficit problem, unless we solve the problem of growing health care expenditures in the Federal budget.

But the President's bill, and virtually all other health care reform proposals before you, would increase net Federal health spending. That means two things:

- First: just to ensure deficit neutrality, you must raise taxes. The added revenue you spend for health care will not be available to pay for education, law enforcement, national defense, deficit reduction, or anything else you may think is important.
- Second: if you are satisfied with deficit neutrality, deficits and health care spending stay on the same unsustainable upward path, so by 2004, health spending will make up over one-third of total Federal outlays and deficits will exceed $350 billion.

The current crop of health care reform proposals are projected to save money only because we compare them to baseline estimates in which national health spending rises to over twenty percent of GDP by 2004. Thus, anything that can claim to hold health care spending to nineteen percent of GDP "saves" money. Do we really want to spend almost one in every five dollars anyone, anywhere in the U.S. produces to pay for health care? I don't know the answer, but we should ask ourselves the question: "Is this good enough?"

On the question of early retiree subsidies, as with any proposed new Federal benefit, it is appropriate to ask ourselves a number of questions:

- Should we create another, only minimally means-tested, entitlement for older Americans?
- Should we create new incentives for early retirement, just as we need older Americans to work longer—just as increased life expectancy and the resulting extension of retirement are putting incredible pressure on existing Federal entitlement programs?
- Should we add to the tax burden of younger workers, many of whom have lower incomes and fewer assets than those whose health care they would be asked to support?
- And, should we choose to expand Federal liabilities when we already cannot pay for the ones we have and are passing on ever bigger bills to our children?

The issue of Federalizing health care benefits for early retirees should be resolved by asking: is this a national priority; how else might we want to spend the plus or minus $3–5 billion/year[1] for the additional early retiree benefit; and, if you decide that this is a national priority, what kind of tax is most appropriate to pay the bills?

Finally, a word of caution. Because of the scope and magnitude of the issues you are addressing, the financial risks to the Federal budget, as well as the rest of the economy, are great. The estimates of the budgetary impact of health care reform will be wrong. Most proposals, not just the President's, are more specific about the benefits they promise than where the savings will come from. While the "scoreability" of savings may be greater for cost containment approaches like premium caps and global budgets than for managed competition, those savings are not necessarily more certain.

Based upon past experience, we know that we tend to underestimate costs and overestimate savings and revenues. In the case of healthcare reform, because we are talking about almost $1 trillion in economic activity, concerning 250 million people, the risk of being wrong in our estimates is significant.

The whole health care debate is about sharing risks and shifting costs. The question is whether Federal government should take on new risks that we either can't or won't pay for.

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[1] The net cost of the additional benefit beginning in 1998 benefit is uncertain and depends entirely on the multiple assumptions made about how many people would be induced to retire, what revenues would be raised from the corporate assessments and individual paybacks, what the premiums would be, etc.

But, here's some the good news—the American people are not as dumb or selfish as some would have us believe. Based upon my travels around the country conducting meetings that allow people to grapple with these very difficult issues, I conclude that:

- People want to understand the issues and know this is an important debate; and
- People can make responsible decisions when given the opportunity and the sufficient information.

People are certainly smart enough to know that they are not getting the information they need on health care reform. They are starting to feel frustrated and manipulated. Could this be contributing to the government's growing credibility problem? I don't know what is worse—people who don't trust government, or government that doesn't trust its people.

Thank you, and I'll be happy to answer any questions you may have.

COMMUNICATIONS

STATEMENT OF A. FOSTER HIGGINS & CO., INC.

Since 1986, Foster Higgins has been tracking trends in employer-sponsored health plans. The Foster Higgins *National Survey on Employer-Sponsored Health Plans 1993* is the largest and most comprehensive report on health care benefits and provides important data for the health care reform debate. The survey results are based on a national probability sample of 2,395 public and private employers. Their responses have been weighted to reflect the demographics of all employers in the United States with 10 or more employees. Therefore, the survey results represent more than 550,000 employers and 68 million full and part-time employees.

Foster Higgins retained the services of Research Triangle Institute, a not-for-profit research organization in North Carolina, to assist in conducting the survey in accordance with rigorous statistical standards. Foster Higgins invested in the new survey methodology because complete, accurate information on both large and small employer health plans is critical to the health care reform debate.

The following tables present some of the results of the '93 Survey pertaining to retiree benefits for the pre-Medicare population.

Percentage of employers offering coverage to retirees under age 65

Number of employees	Percent
10–49	8%
50–199	9%
200–499	12%
500–999	40%
1,000–4,999	37%
5,000–9,999	70%
10,000–19,999	68%
20,000 or More	84%
Under 500	**8%**
500 or More	**42%**

- The percentage offering retiree coverage increases with the size of the employer.

Total health benefit cost, 1993

	Average total health benefit cost per employee	Average cost for retirees only, per retiree:		
		Under age 65	65 and over	All retirees
All responding employers	$3,781	$5,216	$1,786	$2,735

Note: Includes any employee/retiree contributions

- Under 65 retirees cost is 192% higher than the 65 and over retiree cost.

Retiree contribution to health plan for retiree-only coverage

	For retirees under age 65, percentage of plans in which[1]:			Average contribution (% of premium)[2]	For retirees age 65 and over, percentage of plans in which[1]:			Average contribution (% of premium)[1]
	Employer pays all	Retiree pays all	Cost is shared		Employer pays all	Retiree pays all	Cost is shared	
Under 500	22%	73%	5%	26%	22%	73%	6%	40%
500 or More	17%	41%	42%	32%	23%	36%	41%	38%
	N=663				N=618			

Retiree contribution to health plan for retiree and dependent coverage

	For retirees under age 65, percentage of plans in which[1]:			Average contribution (% of premium)[2]	For retirees age 65 and over, percentage of plans in which[1]:			Average contribution (% of premium)[2]
	Employer pays all	Retiree pays all	Cost is shared		Employer pays all	Retiree pays all	Cost is shared	
Under 500	32%	66%	2%	71%	18%	80%	2%	48%
500 or More	2%	39%	60%	38%	21%	37%	42%	37%
	N=661				N=595			

1/ Among employers offering retiree health benefits

2/ Among those requiring contributions of less than 100%

- Smaller employers more likely to require retiree to pay full cost
- Higher contribution percentage required for dependent coverage

Changes made to retiree medical plan within the past two years

Number of Employees	Percentage of employers who have: Increased retiree contribution	Increased cost-sharing	Increased benefits	Tightened eligibility requirements	Changed to defined contribution	Terminated plan	Added freestanding drug plan
10-49	16%	0%	16%	0%	0%	0%	16%
50-199	1%	3%	3%	0%	0%	0%	0%
200-499	16%	18%	5%	1%	0%	1%	0%
500-999	19%	13%	8%	3%	1%	12%	6%
1,000-4,999	23%	14%	10%	9%	1%	2%	12%
5,000-9,999	36%	27%	18%	18%	7%	4%	19%
15,000-19,999	35%	22%	22%	19%	6%	5%	25%
20,000 or More	34%	26%	14%	12%	8%	2%	23%
Under 500	**12%**	**1%**	**12%**	**0%**	**0%**	**0%**	**11%**
500 or More	**23%**	**15%**	**10%**	**7&**	**2%**	**7%**	**10%**
	N=1259						

- Most prevalent change was an increase in retiree contributions.
- Percentage making changes increased with size of employer.

Changes planned for the next two years

	Percentage of employers who intend to:						
	Increase retiree contribution	Increase cost-sharing	Increase benefits	Tighten eligibility requirements	Change to defined contribution	Terminate plan	Add freestanding drug plan
Number of Employees							
10–49	16%	0%	16%	0%	0%	0%	16%
50–199	1%	3%	3%	0%	0%	0%	0%
200–499	15%	17%	5%	1%	0%	1%	0%
500–999	15%	11%	8%	3%	1%	12%	6%
1,000–4,999	19%	12%	10%	8%	1%	2%	9%
5,000–9,999	28%	23%	11%	15%	5%	2%	15%
15,000–19,999	29%	18%	21%	19%	6%	5%	25%
20,000 or More	27%	22%	13%	10%	7%	1%	21%
Under 500	**12%**	**1%**	**12%**	**0%**	**0%**	**0%**	**11%**
500 or More	**18%**	**13%**	**10%**	**7%**	**2%**	**7%**	**9%**
	N=1259						

- Increase in retiree contribution is most often cited as planned change.
- More changes planned as size of employer increases.

STATEMENT OF THE INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS

Mr. Chairman, my name is Frederick Nesbitt and I am the Director of Governmental Affairs for the International Association of Fire Fighters. I appear before you today on behalf of our more than 200,000 members to urge your support for including coverage for retirees under age 65 in the health care reform legislation being considered in your committee.

Providing health care coverage for retirees who are not yet eligible for medicare is an essential component of meeting President Clinton's goal of ensuring "health care that's always there." Indeed, the entire premise of "universal coverage" would be undermined if the millions of Americans who retire before age 65 are excluded from health care coverage.

For fire fighters, the issue of pre-medicare retiree coverage is especially significant. Due to the physical demands of the job, the vast majority of America's professional fire fighters retire well before age 65, with many retiring as early as age 50. Requiring a retired fire fighter, with no income save for his pension, to pay 100% of his health care costs for 15 years would amount to an extraordinary financial hardship.

Because fire fighters routinely retire at relatively young ages, the IAFF believes that a special carve out is warranted for our profession in terms of pre-Medicare coverage. The Administration's pre-Medicare proposal provides coverage for individuals between ages 55–64. While that age range is sufficient for almost all other occupations, it would still leave too many retired fire fighters without health insurance. We therefore recommend that a special provision be added to S. 1757 that provides coverage for all public safety officers who retire at the normal retirement age as established by their particular pension system, consistent with the definition of retirement in the Health Security Act.

Such a carve out for fire fighters is consistent with other federal laws—such as the Federal Employee Retirement System and the Internal Revenue Code treatment of municipal pension systems—which acknowledge the earlier retirement ages of fire fighters by creating a special classification for them.

Mr. Chairman, it would be a grave mistake to assume that pre-medicare retirees are covered by the health plans of their former employer. Studies show that fully 60% of people between age 55–64 who are not working have no health insurance at all, and many others have inadequate coverage.

Even in the fire service, where retiree coverage was once the norm, we are witnessing a dramatic cutback in coverage. Faced with rising health care costs and other strains on municipal budgets, local governments have begun scaling back retiree health coverage—either by reducing benefits or increasing co-payments and deductibles. In some places, retiree coverage has been eliminated altogether.

Perhaps most significantly, our nation's fire fighters need pre-medicare coverage simply because they may never live to become medicare eligible. The physical and emotional strain of our occupation results in fire fighters dying an average of 11 years earlier than the general population. Far too many of our brothers and sisters never live to see their 65th birthday. We do not believe it is asking too much to ensure that these heroes who risked their lives to protect the lives and property of their neighbors receive the same level of health coverage that is being guaranteed for every other American.

Mr. Chairman, I thank you for your attention to this vital issue. I would be happy to answer any questions you may have.

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